STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

PUBLIC HEALTH HEARING SECTION

September 22, 2011

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VIA EMAIL
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VIA EMAIL

RE: Gerson Sternstein, M.D. - Petition No. 2009-200921

Dear Attorney Tynan and Attorney Antonetti:

Enclosed please find a copy of the Memorandum of Decision issued by the **Connecticut Medical Examining Board** in the above-referenced matter.

Sincerely,

Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Public Health Hearing Section

c: Jewel Mullen, MD, MPH, MPA, Commissioner, Department of Public Health
Daniel Shapiro, Assistant Attorney General
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STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Gerson Sternstein, M.D.
License No.: 022391

Petition No. 2009-200921

MEMORANDUM OF DECISION

Procedural Background

On August 10, 2010, the Department of Public Health ("the Department") presented a Statement of Charges ("the Charges") and Motion for Summary Suspension to the Connecticut Medical Examining Board ("the Board") against Connecticut medical license number 022391 of Gerson Sternstein ("respondent"). Board Exh. 1.

The Charges allege that respondent's license is subject to disciplinary action pursuant to the Connecticut General Statutes ("the Statutes") §§ 20-13c(4) and/or 20-13c(5). The Motion for Summary Suspension was based on the Department's information and belief that respondent's continued practice represented a clear and immediate danger to the public health and safety. Board Exh. 1.

Pursuant to the authority of §§ 4-182(c) and 19a-17(c) of the Statutes, on August 17, 2010, the Board granted the Department's motion and summarily suspended respondent's license pending the Board's final determination on the allegations contained in the Charges. The Board set the hearing date for August 27 and 31, 2010. Board Exh. 1

The Department served the Motion for Summary Suspension, Charges, Summary Suspension Order and Notice of Hearing via certified mail, return receipt requested and via electronic mail on August 17, 2010. Board Exh. 1. The Notice of Hearing directed respondent to appear before a duly authorized panel of the Board on August 27, 2010 and August 31, 2010, for a formal hearing on the allegations contained in the Charges. The original panel consisted of Richard Bridburg, MD; Velandy Manohar, MD; and Anne C. Doremus. Board Exh. 1. On August 23, 2010, a Notice of Change in Panel Composition designated Henry Jacobs, MD as a Hearing Panelist and removed Velandy Manohar, MD. (Board Exh. 2). Respondent filed an Answer to the Charges on August 26, 2010. (Board Exh. 3.)

The Board, through its duly authorized panel, held an administrative hearing to adjudicate respondent's case on August 27, August 31, October 1, October 15, November 5, and November 12, 2010. Attorney Richard C. Tynan represented respondent, and Attorney David Tilles represented the Department.

The Panel conducted the hearing in accordance with Chapter 54 (the Uniform Administrative Procedure Act) of the Statutes. Both parties had the opportunity to present evidence, conduct cross-examination, and provide argument on all issues.

All Panel members involved in this decision received copies of the entire record and attest that they either heard the case or read the record in its entirety. The Board reviewed the panel's proposed final decision in accordance with the provisions of § 4-179 of the Statutes. The Board considered whether respondent poses a threat in the practice of medicine to the health and safety of any person. This decision is based entirely on the record and the specialized professional knowledge of the Board in evaluating the evidence. To the extent the findings of fact actually represent conclusions of law, they should be so considered, and vice versa. SAS Inst., Inc., v. S & H Computer Systems, Inc., 605 F.Supp. 816 (Md. Tenn. 1985).

Allegations

1. In paragraph 1 of the Charges, the Department alleges that respondent is, and has been at all times referenced in the Charges, the holder of Connecticut medicine and surgery license number 022391.

2. In paragraph 2 of the Charges, the Department alleges that at various times in 2009 and preceding years, respondent prescribed opioids, benzodiazepines, and/or other controlled substances to patients K.R., T.P., R.O., P.P., M.D., D.T-W., L.W., K.O'C., P.B., and S.B. Respondent's care for one or more of these patients deviates from the standard of care in one or more of the following ways:

    a. his documentation was inadequate;
    b. he made inadequate examinations and/or assessments initially and/or at appropriate interim intervals;
    c. he failed to monitor response to treatment and/or compliance with medication regimens, or monitored inadequately;
    d. he initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies;
    e. he failed to inform, or adequately inform, said patient(s) of risks inherent in the prescribed controlled substances;

f. he prescribed dangerous combinations of drugs;
g. he prescribed inappropriate combinations of drugs;
h. he prescribed excessive doses of opioids;
i. he initiated, continued, and/or increased dosing of opioids despite signs of abuse or criminal behavior by the patient relating to the prescriptions; and/or,
j. he failed to coordinate prescribing with other providers, including, but not limited to dentists, orthopedists, and primary care physicians.

3. In paragraph 3 of the Charges, the Department alleges that the above described facts constitute grounds for disciplinary action pursuant to § 20-13c of the Statutes, including, but not limited to § 20-13c(4); and/or § 20-13c(5).

Findings of Fact

1. Respondent is the holder of Connecticut physician and surgeon license number 022391. See, Respondent's Answer, Board Exh. 3.

2. At all relevant times, respondent practiced psychiatry as a member of Paragon Behavioral Health. Tr. 10/15/10, p. 45.

3. Respondent provided care to K.R. from January 2006 through September 2009. K.R. entered respondent's practice seeking pain medication. K.R. was diagnosed with depression, anxiety, hepatitis C, head injury, cervical neck pain and right knee pain. K.R. had a history of substance abuse. Dept. Exh. 2; Dept. Exhs. 6-9 (sealed); Tr. 8/31/10, pp. 59, 60-65 (sealed); Tr. 10/1/10, pp. 40-77 (sealed); Tr. 10/15/10, pp. 161-248 (sealed).

4. Respondent prescribed K.R. increasingly high doses of oxycodone without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 6- 9 (sealed); Tr. 8/31/10, pp. 59, 60-65 (sealed); Tr. 10/1/10, pp. 40-77 (sealed); Respondent's written record for K.R. is below the standard of care as its notations are barely legible, extremely brief and there are no objective assessments noted. Dept. Exh. 2, Consultant Review by Dr. Ducate and Dept. Exh. 7. Respondent prescribed an inappropriate combination of drugs and a dangerous combination of drugs to K.R. Id. Respondent prescribed an excessive amount of opioids (oxycodone) to K.R. Id. Respondent failed to inform, or adequately inform K.R. of risks inherent to his prescribe controlled substances intake. Id. Respondent initiated, continued and/or increased dosing of opioids in spite of clear signs of abuse or criminal behavior by the patient relating to the prescriptions. Id. Respondent practiced below the standard of care in prescribing controlled substances because the plan of care was completely based upon patient self report and it occurred without an examination of the patient by respondent. Id. Respondent practiced below the standard of care when he prescribed K.R. controlled substances without an assessment that demonstrated objective evidence for the need to prescribe controlled substances. Id. With respect to patient K.R., respondent failed to coordinate the prescribing of controlled substances with other providers. Id. Respondent failed to inform K.R. of the risks inherent in his taking of the controlled substances that were prescribed to him by respondent. Id.

5. Respondent provided care to T.P. from August 2008 through June 2009. Dept. Exhs. 2 and 11. T.P. entered respondent's practice seeking Suboxone for opiate dependence and pain medication. Id. T.P had a history of polysubstance abuse and treatment with prescription opiate medication. Dept. Exh. 2; Dept. Exhs. 10-12 (sealed); Tr. 10/1/10, pp. 77-96, 157, 158, 166-170 (sealed); Tr. 10/15/10, pp. 248-284 (sealed). Respondent's written record for T.P. is below the standard of care as its notations are barely legible, extremely brief and they do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exh. 2, Consultant Review by Dr. Ducate and Dept. Exh. 11. Respondent failed to adequately assess patient T.P. Id. Respondent prescribed an inappropriate combination of drugs and a dangerous combination of drugs to T.P. Id. Respondent prescribed an excessive amount of opioids to T.P. Id. Respondent practiced below the standard of care in prescribing controlled substances because the plan of care was almost exclusively based upon patient self report and it occurred without an examination of the patient by respondent. Id. With respect to patient T.P., respondent failed to coordinate the prescribing of controlled substances with other providers, including the patient's dentist. Id.

6. Respondent prescribed T.P. high doses of opioids and Suboxone without addressing tolerance and potential lethal toxicity or documenting the need for the medication. Respondent also prescribed T.P. a benzodiazepine without any documented reason. Dept. Exh. 2; Dept. Exhs. 10-12 (sealed); Tr. 8/31/10, pp. 65-75 (sealed); Tr. 10/1/10, pp. 77-96, 134, 166-170 (sealed), 134, 166-170.

7. Respondent provided care to R.O. from January 2007 through May 2009. R.O. entered respondent's practice seeking to ease back and neck pain. R.O. had Major Depression and Pain Disorder with Psychological factors. R.O. had a history of drug and alcohol addiction. Dept. Exh. 2; Dept. Exhs. 13-15 (sealed); Tr. 8/31/10, pp. 75-89 (sealed); 10/1/10, pp. 134, 159-164; Tr. 11/5/10, pp. 181-222 (sealed).

8. Respondent prescribed R.O. excessively high doses of opioid medication that R.O. used in combination with antidepressants. Respondent prescribed medication without addressing R.O.'s tolerance or potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 13-15 (sealed); Tr. 8/31/10, pp. 75-89 (sealed); Tr. 10/1/10, pp. 134, 159-164; Tr. 11/5/10, pp. 181-222 (sealed). In May of 2007, respondent prescribed Oxycontin and Percocet to R.O. without seeing and/or examining the patient. Dept. Exhs. 2 and 14. Respondent's patient records for R.O. were inadequate as they lacked detail and did not contain objective evidence for a need for the high doses of Schedule II medicine prescribed by respondent. Id. The clinical notes for patient R.O. are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exh. 2. The assessment of patient R.O. was inadequate and below the standard of care as there is no evidence in R.O.'s record that a response to treatment is assessed through standard measures used to monitor the response of the chronic pain to the treatment. Id. Respondent initiated, continued and/or increased dosing of opioids to R.O. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the urine drugs screens for R.O. indicated that

the patient was also using other opiates that were not prescribed by respondent. Id. This conduct is below the standard of care for physicians in Connecticut.

9. Respondent provided care to P.P. from February 2002 through September 2009. When P.P. entered respondent's practice, she sought help for addiction and admitted to using heroin, cocaine, crack, and prescription opioids. P.P. had Opiate Dependence, cervical disc disease, traumatic injury and Chronic Obstructive Pulmonary Disease ("COPD"). Dept. Exh. 2; Dept. Exhs. 16-19 (sealed); Tr. 8/31/10, pp. 89-94 (sealed); Tr. 11/5/10, pp. 178-181 (sealed).

10. Respondent prescribed P.P. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 16-19 (sealed); Tr. 8/31/10, pp. 89-94 (sealed); Tr. 11/5/10, pp. 178-181 (sealed). The clinical notes for patient P.P. are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2 and 17. The assessment of patient P.P. was inadequate and below the standard of care as there is no evidence in the P.P.'s record that a response to treatment is assessed through standard measures used to monitor the response of the chronic pain to the treatment. Id. Respondent failed to inform this patient of the risks inherent in the prescribed controlled substances. Id. Respondent failed to coordinate prescribing with P.P.'s other providers. Id. Respondent initiated, continued and/or increased dosing of opioids to P.P. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the patient was using cocaine. Id.

11. Respondent provided care to M.D. from January 2002 through September 2009. M.D. entered respondent's practice seeking help for depression and arm and neck pain. M.D. had a history of polysubstance abuse and treatment with prescription opiate medication. Dept. Exh. 2; Dept. Exhs. 20-22 (sealed); Tr. 8/31/10, p. 106; Tr. 11/5/10, pp. 170-178 (sealed).

12. Respondent prescribed M.D. excessively high doses of opioid medication without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 20-22 (sealed); Tr. 8/31/10, pp. 116-119, 124-125; Tr. 10/1/10, pp. 191-197; Tr. 11/5/10, pp. 170-178 (sealed). Respondent's documentation and treatment were inadequate in that there were no objective assessments noted in the record, and the plan of care was only based upon the patient's self report. Dept. Exhs. 2 and 21. In addition, the documentation lacked sufficient detail and the notes were barely legible, extremely brief and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Risks, benefits and the alternatives to treatment were not explained to M.D. Id. Respondent initiated, continued and/or increased dosing of opioids to M.D. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the urine drugs screens for M.D. indicated that the patient was also using other opiates that were not prescribed by respondent. Id.

13. Respondent provided care to D.T-W. from January 2008 through September 2009. D.W. entered respondent's practice seeking to ease back pain and lack of sleep. D.T-W.'s urine

toxicology screens revealed the presence of cocaine and methadone, but no Suboxone. Dept. Exh. 2; Dept. Exhs. 23-26 (sealed); Tr. 8/31/10, pp. 130-152 (sealed); Tr. 11/5/10, pp. 152-170 (sealed). The patient's medical record indicated that she was crushing and snorting 70-120 mg of Percocet per day. Dept. Exh. 24. The records for D.T.-W. are inadequate in that there are not notes of physical examinations and very few objective observations. Dept. Exh. 2. Respondent practiced below the standard of care for patient D.T-W. in that he prescribed controlled substances for this patient despite clear evidence that this patient was engaged in criminal activity and/or abusive behavior with respect to the prescriptions and other drugs. Dept. Exh. 2.

14. Respondent prescribed D.T-W. a combination of opioids and Suboxone without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 23-26 (sealed); Tr. 10/1/10, pp. 195, 196; Tr. 8/31/10, pp. 130-152 (sealed); Tr. 11/5/10, pp. 152-170 (sealed). The patient records are inadequate in that they are barely legible, extremely brief and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2 and 24. Respondent failed to inform the patient of risks inherent in the prescribed controlled substances. Id. Respondent prescribed a dangerous and or inappropriate combination of drugs in that he prescribed Suboxone to this patient despite the fact that the patient is dependent on opiate agonists. It is below the standard of care to prescribe opiates with Suboxone as drug interactions are a risk, and it lowers the effectiveness of both drugs. Also, serious withdrawal symptoms can emerge as well as an increased risk of opiate abuse if these drugs are combined in this manner. Id.

15. Respondent provided care to L.W. from July 2002 through February 2009. L.W. entered respondent's practice seeking to ease severe pain. L.W. had a history or depression and schizoaffective disorder, as well as multiple medical conditions. Dept. Exh. 2; Dept. Exhs. 27- 29 (sealed); 11/5/10, pp. 222-259 (sealed).

16. Respondent prescribed L.W. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 27- 29 (sealed); 11/5/10, pp. 222-259 (sealed); 11/12/10, pp. 106-118 (sealed), 101-105. The documentation for patient L.W. was inadequate as there are no objective assessments are noted, the plan of care is based only on the patient's self report and the records lacked sufficient detail. Dept. Exhs. 2 and 28. Respondent failure to communicate with the patient's dentist who may have been prescribing pain medication as well was below the standard of care for physicians in Connecticut. Dept. Exh. 2. Respondent prescribed a dangerous and inappropriate combination of drugs for L.W. during August of 2008 and January of 2009. Respondent also failed to appropriately and adequately assess the patient during treatment. Id.

17. Respondent provided care to K.O'C. from June 2000 through June 2009. K.O. entered respondent's practice seeking to ease pain and was in treatment for depression and anxiety. K.O. had a history of drug and alcohol addiction. The patient's records also indicated that there was narcotic analgesic abuse evident and that the patient had engaged in drug seeking behavior for Vicodin. Dept. Exh. 2; Dept. Exhs. 31-33 (sealed); Tr. 8/31/10, pp. 152-160 (sealed). Respondent prescribed excessive doses of drugs to this

patient despite the fact that the patient's orthopedic evaluation did not find objective evidence to support the patient's report of debilitating pain. Dept. Exhs. 2, 31-33. On January 15, 2007, respondent prescribed "Oxycontin 80 mg, 17 tablets per day, #240 total tablets, Xanax 1 mg, 4 tablets per day and #60 tablets, with 2 refills, and 40 mg Oxycontin, 8 tablets per day and #120 tablets." Id. The Board finds that these prescriptions at these doses in one visit without any objective evidence is a violation of the standard of care. Respondent initiated, continued and/or increased dosing of opioids to K.O-C. despite the fact that the patient had a history of drug and alcohol addiction and despite the fact that the urine drugs screens for K.O'C. indicated that the patient was also using other drugs that were not prescribed by respondent. Id.

18. Respondent prescribed K.O'C. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 31-33 (sealed); Tr. 8/31/10, pp. 152-160 (sealed); Tr. 10/1/10, p. 196. The clinical notes for this patient are inadequate in that they are barely legible, extremely brief, and do not indicate a patient's condition and behavior. Dept. Exhs. 2 and 32.

19. Respondent provided care to P.B. from October 2001 through November 2008. P.B. entered respondent's practice for insurance purposes and wanted to continue on her then-current medication regimen. P.B. was taking pain medication and psychotropic medication for depression and anxiety. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36-41 (sealed); Tr. 8/31/10, pp. 162-170, 185-199 (sealed); Tr. 10/1/10, pp. 170-171, 175-182, 197-199 (sealed); Tr. 11/5/10, p. 103.

20. As early as March 2003, P.B. was documented by New Britain General Hospital for abusing prescription medication. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36- 41 (sealed); Tr. 8/31/10, pp. 186, 187 (sealed).

21. Respondent prescribed P.B. excessively high doses of opioid medication in combination with other addictive medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36-41 (sealed); Tr. 8/31/10, pp. 162-170, 185-199 (sealed); Tr. 10/1/10, pp. 170-171, 175-182, 197-199 (sealed); Tr. 11/5/10, pp. 101- 150 (sealed). Respondent prescribed an inappropriate combination of drugs to P.B. Dept. Exhs. 2 and 35-36. The Board agrees with Dr. Ducate's assessment that the "practice of prescribing massive doses of Schedule II controlled substances, as well as other sedating medication is well below the community standard of care, especially with [the patient's] history of hospitalizations due to opioid toxicity and her history of unreliable reporting of her medication use." Id. The clinical notes for this patient are inadequate in that they are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Id. Respondent made inadequate examinations and assessments. Id. Respondent failed to inform this patient of the risks inherent in the prescribed controlled substances. Id. Respondent initiated, continued and/or increased dosing of controlled substances despite clear evidence that the patient was misusing and abusing the medication. Id.

22. In January 2009, P.B. died due to opiate toxicity. Dept. Exh. 2; Dept. Exhs. 34, 35a, 35b, 36-41; Tr. 10/1/10, pp. 170-171, 175-182 (sealed); Tr. 11/5/10, pp. 138-150 (sealed).

23. Respondent provided care to S.B. from September 2001 through September 2009. S.B. entered respondent's practice for depression, sleep and pain problems. S.B. had a history of drug abuse that discontinued in 1977, Hepatitis B, Hepatitis C, chronic narcotic addiction, hypertension and depression. Dept. Exh. 2; Dept. Exhs. 42-51 (sealed); Tr. 8/31/10, pp. 170-185, 199-209 (sealed); Tr. 10/1/10, pp. 170-171, 183-191 (sealed); Tr. 11/5/10, pp. 10-101 (sealed).

24. Respondent prescribed S.B. excessively high doses of opioid medication in combination with other addictive and sedative medications without addressing tolerance and potential lethal toxicity. Dept. Exh. 2; Dept. Exhs. 42-51 (sealed); Tr. 8/31/10, pp. 170-185, 199-209 (sealed); Tr. 10/1/10, pp. 170, 171, 183-191 (sealed); Tr. 11/5/10, pp. 10-101 (sealed). The clinical notes for this patient are inadequate in that they are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2, 43, and 46. Respondent failed to inform the patient of risks inherent in the prescribed controlled substances. Id. Respondent initiated, continued and/or increased dosing of controlled substances despite clear evidence that the patient was misusing and abusing the medication and despite evidence that the patient was addicted to controlled substances. Id.

25. In February 2009, S.B. died due to hypertrophic dilated cardiomyopathy. The toxicology report revealed the presence of prescribed medication. Dept. Exh. 2; Dept. Exhs. 42-51 (sealed); Tr. 8/31/10, pp. 170-185, 199-209 (sealed); Tr. 10/1/10, pp. 170, 171, 183-191 (sealed).

26. Generally, and as specifically noted throughout this Memorandum of Decision, respondent's documentation was inadequate. Respondent's clinical notes were illegible and he failed to document medical justification or objective observations for his elected plan of treatment for each patient. Dept. Exh. 2; Tr. 8/31/10, pp. 56-59; Tr. 10/1/10, pp. 34-35, 43-46, 73, 74; Tr. 10/15/10, p. 196.

27. Generally, and as specifically noted throughout this Memorandum of Decision, respondent made inadequate examinations and/or assessments initially and/or at appropriate interim intervals. Dept. Exhs. 2, 3; Tr. 8/31/10, pp. 59, 60-206 (sealed); Tr. 10/1/10, pp. 37, 40-96.

28. Generally, and as specifically noted throughout this Memorandum of Decision, respondent failed to monitor his patients' response to treatment and/or compliance with medication regimens, or monitored inadequately. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 8/31/10, pp. 59, 60-206 (sealed); Tr. 10/1/10, pp. 37, 40-96; Tr. 11/5/10, pp. 10-259 (sealed).

29. Generally, and as specifically noted throughout this Memorandum of Decision, respondent initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies. Dept. Exhs. 2, 3; Tr. 10/1/10, pp. 37, 40-96; Tr. 10/15/10, pp. 99-103, 108-118; Tr. 11/5/10, pp. 10-101, 160-163 (sealed).

30. Generally, and as specifically noted throughout this Memorandum of Decision, respondent failed to inform, or adequately inform, patient(s) of risks inherent in the prescribed controlled substances. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 10/1/10, pp. 72-74 (sealed). There is no evidence in the ten patient records which demonstrates that respondent informed patients of the risks inherent in the controlled substances he was prescribing. Dept. Exhs. 2, 7, 11, 14, 17, 21, 24, 28, 31-33, 35-36, 43 and 46.

31. Generally, and as specifically noted throughout this Memorandum of Decision, respondent prescribed dangerous combinations of drugs. Dept. Exhs. 2, 3; Dept. Exhs. 6-29, 31-51 (sealed); Tr. 8/31/10, pp. 40-46; Tr. 10/1/10, pp. 40-96 (sealed); 165-166, 190, 191.

32. Generally, and as specifically noted throughout this Memorandum of Decision, respondent prescribed inappropriate combinations of drugs. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 8/31/10, pp. 40-46; Tr. 10/1/10, pp. 40-96 (sealed), 19-26, 74-76, 190, 191.

33. Generally, and as specifically noted throughout this Memorandum of Decision, respondent initiated, continued, and/or increased dosing of opioids in spite of signs of abuse or criminal behavior by patients relating to the prescriptions. Dept. Exhs. 2, 3; Dept. Exhs. 6- 29, 31-51 (sealed); Tr. 10/1/10, pp. 90-95 (sealed), 132-134, 137-144, 192-197.

34. Generally, and as specifically noted throughout this Memorandum of Decision, respondent failed to coordinate prescribing with other providers, including, but not limited to dentists, orthopedists, and primary care physicians. Dept. Exh. 2; Dept. Exhs. 6-12, 16-19, 27-29 (sealed); Tr. 10/1/10, pp. 70-77; Tr. 11/5/10, pp. 100, 101, 149, 150 (sealed).

35. Dr. Sternstein's testimony is wholly unreliable and not credible.

36. Dr. Ducate's written opinions and oral testimony are reliable and credible.

Discussion and Conclusions of Law

The Department bears the burden of proof by a preponderance of the evidence in this matter. Goldstar Medical Services, Inc., et al. v. Department of Social Services, 288 Conn. 790, 820-21 (2008). Although the burden of proof is a preponderance of evidence, the Board finds

that the Department provided overwhelming credible evidence that respondent practiced medicine significantly below the standard of care for physicians in Connecticut. The respondent's testimony was not reliable or credible, and specifically it was not reliable or credible regarding his explanations for his treatment and prescribing of controlled substances to his patients. The Department presented reliable and credible evidence that clearly demonstrated that respondent's treatment of his patients, as more fully described below, was significantly below the standard of care for physicians in Connecticut. The Board agrees with Dr. Ducate's opinion that there is "**a clear pattern of substandard medical care provided by Dr. Gerson Sternstein that is grossly below**" the standard of care. (emphasis supplied). Exh. 2, p. 2.

After reviewing all of the evidence in this matter, the Board finds that respondent poses a serious threat in his practice of medicine to the health and safety his patients. The Board finds that respondent's practice of medicine is far below the standard of care and is dangerous. Respondent's conduct, as described in this Memorandum of Decision, constitutes illegal, incompetent or negligent conduct in the practice of medicine in violation of Conn. Gen. Stat. § 20-13c(4).

Section 19a-10 of the Statutes provides in pertinent part, "[Boards] may conduct hearings on any matter within their statutory jurisdiction. Such hearings shall be conducted in accordance with Chapter 54 and the regulations established by the Commissioner of Public Health."

Pursuant to § 20-13c(4) of the Statutes "the board is authorized to restrict, suspend, or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for . . . illegal, incompetent or negligent conduct in the practice of medicine." The board finds that the Department met its burden of proof with respect to the Charges.

With respect to paragraphs 1 of the Charges, the evidence establishes that respondent is a licensed physician in the State of Connecticut who practices psychiatry. Respondent admitted to this Charge in his Answer. See, Board Exh. 3.

With respect to paragraph 2a of the Charges, the Department proved by a preponderance of the evidence that respondent's documentation was inadequate, in violation of the standard of care. See, Findings of Fact ("FF") 4, 5, 8, 10, 12, 13, 14, 16, 18, 21, 24 and 26. There is clear evidence of poor documentation throughout the ten charts at issue. Id. Due to illegibility, it was impossible to read a vast number of entries. In fact, in testimony, respondent states, "I'm not

sure what even I wrote, I can't read my writing Tr. 11/5/10, p. 120, and that he used block letters to obtain a motorized wheelchair because, "they need to be able to read my writing." Tr. 11/5/10, p. 121. Generally, the clinical notes for the patients are inadequate in that they are barely legible, extremely brief, and do not indicate the results of a physical exam and rarely contain mental status exam or an observation of the patient's condition and behavior. Dept. Exhs. 2.

With respect to paragraph 2b of the Charges, the Department met its burden of proof that respondent made inadequate examinations and/or assessments initially and/or at appropriate interim intervals. See, FF 4, 5, 8, 10, 12, 13, 14, 16, 18, 21, 24, and 27. In reviewing the 10 patient records, there may be chronic pain diagnoses and in some cases the underlying pathology can be inferred, but there is no evidence of any physical examination at the initial interview or thereafter even with patients in treatment for many years. Id. In prescribing increasing doses of narcotics for a particular problem, the standard of care requires that there be clear documentation of an exacerbation in the patient's condition evidenced by reports from a physiatrist, orthopedist, or rheumatologist caring for the patient, or the prescriber must personally examine and document reasons for changing the prescribing pattern. Dept. Exh. 2.

Instead, respondent placed heavy, and in many cases, exclusive reliance upon the patients' statements about pain. Dept. Exh. 2 and Tr. 8/31/10, p. 181. There is little or no documentation of any examination of patients. Dept. Exh. 2.

With respect to paragraph 2c of the Charges, a preponderance of the evidence establishes that respondent failed to monitor the patient's responses to treatment and/or compliance with medication regimens, or monitored inadequately in violation of the standard of care. FF 4, 6, 8, 10, 24 and 28. Respondent agreed with the Connecticut State Guidelines and with Dr. Ducate, the Department's expert, that response to treatment and compliance with medications must be monitored. Tr. 10/15/10, p. 282 (sealed). Yet, the record is replete with examples of patients' probable abuse of controlled substances that respondent failed to monitor.

With respect to paragraphs 2c, 2f, 2g, 2h and/or 2i, of the Charges, the Department sustained its burden of proof that respondent violated the standard of care when he failed to monitor or inadequately monitored his patients' response to treatment and/or compliance with medication regimens, and initiated, continued, and/or increased dosing of opioids in spite of

signs of abuse or criminal behavior by the patient relating to the prescriptions. FF 4, 6, 8, 10, 12, 13, 14, 17, 21, 24, 28, 29 and 33.

P.B. was prescribed high doses of Duragesic, Dilaudid, Fentora, methadone and Norco, Klonopin, Valium, Seroquel, Flexeril, Xanax, and was on Soma. Dept Exhs. 34-41 (sealed). P.B.'s records show that P.B. had liver dysfunction. Yet respondent did not conduct any liver testing before or after the liver dysfunction was discovered in the hospital. Dept. Exhs. 34-41 (sealed).

P.B. was under respondent's care from October 2001 through November 2008. As early as March 2003, New Britain General Hospital documented that P.B. had bizarre behavior, organic mental syndrome and opiate withdrawal. FF. 19. Respondent prescribed P.B. Fentora, Methadone, Xanax, Soma, Dilaudid and Duragesic, bringing P.B.'s dosage back up without any explanation. In February 2007, P.B. was admitted to New Britain General Hospital due to lethargy and mental status changes due to opioid abuse. From April 2007 through June 2007, P.B.'s liver function tests were abnormal and her opioid levels were increased. In May and June of 2007, P.B. was again hospitalized. P.B.'s hospital records indicated that P.B. had a primary problem of opiate toxicity during her May and June 2007 admissions. Despite hospital admissions indicating P.B.'s opiate toxicity and addiction, respondent continued to prescribe P.B. high doses of opiate medication in addition to other medications that resulted in sedation and respiratory depression. FF. 21. On December 2, 2008, P.B. died of opiate toxicity at age 52, as stated in the hospital records.

Respondent began treating SB in September 2001. Dept. Exh. 43 and 46, FF. 23-25. Throughout SB's treatment respondent prescribed high doses of Vicodin, Soma, Effexor, Triazadone, Valium, Ritalin, Flomax, Duragesic, Oxycontin and Seroquel to SB who suffered from liver disease, depression, hypertension, and chronic back pain. Id. Beginning on or about July 16, 2008 through August of 2009, SB had several episodes in which SB experienced confusion and disorientation from opiate abuse or narcotic overdoses, sometimes causing SB to fall and require hospitalization. Dept. Exh. 44-49 (sealed). Hospital records indicate that in March 2009, the Valium and Soma were stopped and SB improved, and by August 2009, all of SB's medications were tapered or discontinued, including methadone or other narcotics. Dept. Exh. 44-49 (sealed). Despite SB's hospital history regarding drug overdoses and addictions and marked improvements once those medication were reduced or stopped, respondent resumed

prescribing narcotics to SB. Dept. Exh. 44-49 (sealed). On June 3, 2009, SB was prescribed 20 mg of methadone four times a day. On June 10, 2009, SB was prescribed 40 mg. four times a day of methadone. Respondent's last prescription to SB was on June 18, 2009, but only because SB was no longer available to respondent.

Additionally, as noted by Dr. Ducate, several of respondent's patients tested positive for illicit drugs. Specifically, substances such as heroin, cocaine, and morphine were found in urine screens of respondent's patients, providing respondent significant reason to believe his patients were engaging in drug abuse. Moreover, respondent had patients who were receiving Medicaid for their prescription, but they would pay cash in the thousands of dollars for name brand prescriptions, a red flag for possible diversion of drugs. Despite serious signs of abuse or criminal behavior, respondent continued to prescribe high, and sometimes lethal doses of opiates to his patients.

For example, respondent provided care for P.P. from February 2002 through September 2009. FF 9. P.P. had a history of detoxification from crack cocaine, heroin and opioids. P.P. used heroin on the day of admission into respondent's practice. Tr. 8/31/10, p. 91 (sealed). P.P. had a diagnosis of COPD. Tr. 11/5/10, p. 179 (sealed). Given this diagnosis, coordinating care with a pulmonologist was important due to the potential respiratory depression with large doses of opioids that the patient received by respondent's prescription. There is no evidence that this was done. Additionally, P.P. had a conviction for assault and possession of drug paraphernalia, multiple urine reports with cocaine present and diluted urine specimens. Tr. 11/5/10, p. 179 (sealed). Essentially, all of these are red flags for risk of diversion and/or addiction. Yet, respondent took no action.

M.D. was under respondent's care from January 30, 2002 through September 16, 2009. M.D. had urine toxicology screens for cocaine and marijuana, and many negatives screens for methadone and fentanyl, which were his prescribed medications. Tr. 10/1/10, p. 133; Tr. 11/5/10, pp. 153-163 (sealed). M.D. informed respondent that he got "old morphine from a friend." Despite these red flags, they did not appear to raise any concerns for respondent about potential diversion and addiction.

Between 2008 and 2009, D.T-W. had positive urine tests for cocaine and methadone, yet D.T-W. tested negative for Suboxone, which was prescribed for him. D.T-W. was opiate-dependent for two years and took 70 to 120 mg. of Percocet, which D.T-W. crushed and snorted.

D.T-W. bought medications from patients in pain clinics in Bristol and Meriden. Yet, there is no evidence of any action taken by respondent regarding potential diversion or abuse by D.T-W.

L.W. had a medical history of asthma and sleep apnea. Dept. Exh. 28 (sealed). Yet there was no pulmonologist involved in the coordination of care for L.W. at any time during L.W.'s treatment for prescription of opioids that can cause pulmonary depression.

Respondent provided care to K.O'C. from June 27, 2000 through June 18, 2009. FF. 17. K.O. was being weaned off of narcotics as of the initial visit on June 27, 2000. The Connecticut Department of Social Services required K.O. to be in a drug-lock program to avoid insurance abuse. Dept. Exh. 32 (sealed). So K.O'C. paid cash for Xanax for about a year at Wal-Mart to avoid detection. Further, K.O'C. was buying Oxycontin on a monthly basis for $1,600.00 or more, while living on disability payments. Dept. Exh. 33 (sealed). Respondent appealed to Humana Clinical Pharmacy twice on K.O'C's behalf because Humana refused coverage for K.O. Respondent stated that K.O. needed brand name Oxycontin, and that he was doing regular tests to rule out any diversion by K.O. Dept. Exh. 32 (sealed). The evidence establishes, however, that respondent only did one serum test on August 2, 2005, and one on December 17, 2003. Respondent's appeal to Humana was denied twice.

With respect to paragraph 2d of the Charges, the Department sustained its burden of proof that respondent deviated from the standard of care when he initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies. FF 8, 12, 17 and 29. Dept. Exhs. 2, 14, 21, 24, 31-33. In the cases of R.O., M.D., D.T.W., and K.O'C., although their urine testing was not consistent with respondent's prescriptions, respondent continued to give them prescriptions. Tr. 10/1/10, p. 196. FF 8, 12, 17 and 29. Dept. Exhs. 2, 14, 21, 24, 31-33.

With respect to paragraph 2e of the Charges, the Department met its burden of proof that respondent deviated from the standard of care when he failed to inform, or adequately inform, patients of risks inherent in the prescribed controlled substances. Dept. Exh. 2, 7, 11, 14, 17, 21, 24, 28, 31-33, 35-36, 43 and 46; FF 4, 10, 12, 14 21, 24 and 30. There is no evidence in any of the ten cases that respondent talked with his patients about the potential risks and benefits of his treatment or alternative treatment, or that respondent made a written treatment plan regarding their care. Id. Respondent stated that he discusses risks and benefits of treatment in pain group, stating, "if they are getting pain medications from me, they're coming." However, at best, only

half of the ten patients attended the pain group. Tr. 10/15/10, pp. 66-70 (sealed). Respondent's testimony that some of the patients received counseling about the risks of the controlled substances is not sufficient or credible.

With respect to paragraphs 2f, 2g and/or 2i, a preponderance of the evidence establishes that respondent deviated from the standard of care when he prescribed dangerous and inappropriate combinations of drugs. FF 4, 5, 8, 10, 12, 14, 16, 17, 18, 21, 24, 31 and 32. Respondent used extremely high doses of opiates, often with benzodiazepines, sometimes with Suboxone, and often with several other drugs. He stated he only knew one other physician in the state who prescribed opiates like he did. Tr. 11/12/10, p. 45. Medications with serious side effects need to be clearly monitored and reasons for changing medications and dosages should be clearly documented. Dept. Exh. 2. In this case, respondent repeatedly failed to meet the standard of care. FF 4, 5, 8, 10, 12, 14, 16, 17, 18, 21, 24, 31 and 32, and Dept. Exh. 2. Some examples regarding this finding are as follows:

T.P. was prescribed Lyrica, Ativan, Percocet, Oxycontin, and Suboxone. Dept. Exh. 11 Yet, the combination of short-acting pain relievers makes it difficult to know which medications are effective and which ones are not. Dept. Exhs. 10-12 (sealed). Further, Percocet should not be used in conjunction with Soma because the acetaminophen in the Percocet can cause liver toxicity. R.O. was prescribed the same combination of Percocet and Soma, which in addition to liver toxicity, can also cause hallucinations and death. Dept. Exhs. 13-15 (sealed). Respondent failed to conduct any liver function studies as required by the standard of care when prescribing these combinations of medications, and there is no explanation in the charts as to why he prescribed T.P. and R.O. this combination of drugs. Dept. Exhs. 10-15 (sealed).

P.P. was prescribed high doses of Oxycontin, methadone, Roxycontin, and Xanax. Dept. Exhs. 16-19. The record is unclear as to why respondent prescribed both Oxycontin and Roxycontin when they are essentially the same thing. There is no documented rationale or explanation in the records of this patient. Dept. Exh. 2.

M.D. was prescribed high doses of Oxycontin, methadone, Roxycontin, Xanaflex, and fentanyl. M.D. tested negative 24 times for methadone and Fentanyl, although prescribed, and also ran out of the prescription early, yet M.D.'s prescriptions were refilled several times. Dept. Exhs. 20-22 (sealed).

D.W. was prescribed high doses of Suboxone, Oxycontin, Dilaudid, Opana, Soma and Percocet containing 5.2 mg. of acetaminophen per day. No liver function tests were ordered on D.W. The combination of benzodiazepines found in the urine, but not prescribed, plus Oxycontin, Percocet, and Opana in high doses is dangerous. Dept. Exh. 23-26 (sealed). Respondent's explanation for continuing to fill DTW's prescriptions is that another doctor prescribed D.W. the Opana and the benzodiazepines. Tr. 11/5/10, p. 157 (sealed). The board finds respondent's claim not to be credible because the other doctors' records do not show such prescriptions. Moreover, even when D.W.'s urine tested positive for cocaine and methadone, respondent continued to prescribe to D.W. Dept. Exh. 23-26 (sealed).

Respondent prescribed L.W. Fentora and Actiq, which are two forms of fentanyl: lozenge and tablet. Dept. Exhs. 27-30 (sealed). Respondent also prescribed to LW, Roxycodone and oxycodone, which are also the same drug. Dept. Exhs. 27-29. The Board finds that respondent did not adequately justify his prescription of the same drugs in two different forms, and instead created circumstances that heighten the risk for diversion.

With respect to paragraph 2h of the Charges, the Department sustained its burden of proof that respondent prescribed excessive doses of opiates in violation of the standard of care. Respondent failed to provide sufficient medical justification or an objective need for prescribing high doses of opiates and placed each patient at high risk of overdose or dependency. FF. 4, 8, 10, 12, 13, 17, 21, 24, 28, 29 and 33. Dept. Exhs. 2, 7, 11, 14, 17, 21, 24, 28, 31-33, 35-36, 43 and 46.

With respect to paragraph 2j of the Charges, a preponderance of the evidence establishes that respondent failed to coordinate prescribing with other providers, including, but not limited to dentists, orthopedists, and primary care physicians. FF. 4, 5, 10, 16. Communication with a patient's treating provider is necessary to avoid duplication and disruption of treatment, and negative drug interactions. Respondent's records indicate that L.W., P.P. and T.P. were each prescribed pain medication secondary to dental procedures, and that K.R. was provided multiple prescriptions from more than one doctor. Dept. Exhs. 6-12, 16-18, 27-29 (sealed). Despite the known existence of other treating providers, there is no evidence that respondent coordinated with these patients' other providers to ensure the safety and efficacy of respondent's treatment plan.

In reviewing the record in its entirety, it is the opinion of the Board that the expert for the Department is reliable and credible. Respondent, on the other hand, was not credible in his testimony. When pressed to explain his rationale for prescribing in specific cases, he repeatedly deflected and reverted to theories.[1] His explanation of the use of multiple pharmacies was not credible.

While respondent claims that it is safe to give very large doses of opiates "so long as they are titrated upward properly," he did not always comply with this approach. He stated, " I tell people that they have to assume that I'm giving them a prescription for a gun with bullets. (Tr. 10/15/10, p. 82)." He also stated, "I think if someone were to do this [his kind of pain management] they'd have to be part of a group or part of a hospital or part of a university. This is tertiary [sic] care medicine . . . . (Tr. 11/12/10, p. 77)."

Respondent engages in a practice of prescribing medications that is significantly below the standard of care. His patient records are void or scant of information relating to testing, assessments, practitioner collaboration, informed risks and alternatives, or medical justification. Dept. Exh. 2. Instead, in many cases he simply has allowed patients to self-report their pain to acquire a prescription. The Board believes respondent has failed to demonstrate that he is able to practice medicine with reasonable skill and safety. Respondent's failure to recognize the inadequacies and dangers posed by his practice is extremely concerning to this Board. The Board finds that respondent presents a significant and real danger to patients in Connecticut.

Order

Based upon the record in this case, the above findings of fact and the conclusions of law, and pursuant to the authority vested in it by §§ 19a-17 and 20-13c of the Statutes, the Board finds that the misconduct alleged and proven is severable and warrants the disciplinary action imposed by this order.

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[1] Respondent also testified that he teaches patients how to carry their medications in case they are pulled over by the police, and if a pharmacy refuses to fill a script to "swallow hard" and say "well, ok. I guess I'll take my business elsewhere." He tells the patients that they might hear from pharmacists that there is a problem with "Me." At the same time the respondent admits to using several pharmacies for the same patient and the same drug. He states that this is because he prescribes so much that he is being considerate to other customers of the pharmacies in case they run out of opiates. He also states that usually three pharmacies are involved and the pharmacists know and are part of the treatment team. Respondent also stated that he has no documentation of this. At another point in his testimony, when he was asked if Walgreens knew that the same patient was getting more of the same drug from another pharmacy, respondent stated, "I can't speak exactly of what other people know." Tr. 11/12/10, p. 15. This testimony is not credible. The practice of pharmacies is to have all drugs for a patient dispensed in one place. There is no problem for pharmacies to get opiates in any amount. Further, this teaches patients some of whom are addicts of illicit drugs, to go to multiple pharmacies which is anti-therapeutic and against federal and state guidelines for prescribing. See Tr. 11/5/10, pp. 185, 201.

The Board orders that in Petition No. 2009-200921:

1. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient K. R., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
2. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient T.P., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
3. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient R.O., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
4. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient P.P., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
5. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient M.D. , and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
6. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient D.T.-W., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
7. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient L.W., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,
8. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of

patient K.O.'C ., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,

9. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient P.B., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,

10. Respondent's license number 022391 to practice as a physician and surgeon in the State of Connecticut is hereby REVOKED based upon his care and treatment of patient S.B., and respondent is assessed a civil penalty of five thousand dollars ($5,000.00); and,

11. Respondent shall pay the civil penalties described above which equal a total of fifty thousand dollars ($50,000.00) by certified or cashier's check payable to "Treasurer, State of Connecticut." The check shall reference the Petition Number on the face of the check, and shall be payable within thirty days of the effective date of this Decision.

12. All correspondence related to this Memorandum of Decision and payment of the civil penalty must be mailed to:

Bonnie Pinkerton, Nurse Consultant
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

13. This Memorandum of Decision is effective on September 20, 2011.

September 20, 2011

Anne C. Doremus

By: Anne C. Doremus, Chairperson
Connecticut Medical Examining Board

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes § 4-180(c), a copy of the foregoing Memorandum of Decision was sent this 21st day of September 2011, by certified mail, return receipt requested to:

Richard C. Tynan, Esq.
Halloran & Sage
One Goodwin Square
225 Asylum Street
Hartford, CT 06103-4303

Certified Mail RRR #7004-1160-0000-8837-0227

and via email to:

Matthew Antonetti, Principal Attorney
Legal Office
Department of Public Health
410 Capitol Avenue, MS #12LEG
Hartford, CT 06134-0308

Jeffrey A. Kardys
Administrative Hearings Specialist/Board Liaison
Department of Public Health
Public Health Hearing Office

STATE OF CONNECTICUT
CONNECTICUT MEDICAL EXAMINING BOARD

Gerson Sternstein, MD
c/o Richard C. Tynan, Esq.
Halloran & Sage, LLP
One Goodwin Square
225 Asylum Street
Hartford, CT 06103

Certified Mail RRR #7004-1160-0000-8836-5896
and Via EMAIL

RE: Gerson Sternstein, MD - Petition No. 2009-200921

By authority of the General Statutes of Connecticut, Section 4-177, you are hereby notified to appear before a panel of the **Connecticut Medical Examining Board,** to include **Anne Doremus; Richard Bridburg, MD;** and **Velandy Manohar, MD,** for a hearing on the attached Charges.

The hearing will be held at the Department of Public Health, 410 Capitol Avenue, Hartford, Connecticut as follows:

1. **Friday, August 27, 2010, at 9:30 a.m.; second floor conference room F.**
2. **Tuesday, August 31, 2010, at 9:30 a.m.; Office of Health Care Access hearing room, third floor.**

The scheduling of your case is subject to change. You are urged to call (860) 509-7648 the day before the hearing to verify this schedule.

These charges are being brought against you under the provisions of §§ 19a-9, 19a-10, 19a-14, 19a-17 and 20-13c.of the Connecticut General Statutes. The hearing will be conducted in accordance with Chapter 54 of the General Statutes of Connecticut and § 19a-9-1, et seq., of the Regulations of Connecticut State Agencies (Public Health Code).

Filing an Answer; Failure to File Answer:

You are required to file an answer to the attached Charges with the Department of Public Health *prior to the above scheduled hearing* or *within 14 days from the date of this Notice of Hearing*.
Please note: failure to file an Answer could result in the allegations being found to be true as stated, and the possibility that you will not be permitted to submit any evidence concerning the allegations.

Representation by an Attorney:

At the aforementioned hearing you may be represented by an attorney and present evidence on your behalf. Although you may represent yourself (pro se), you are urged to obtain the services of an attorney. At the hearing you will have the opportunity to present your evidence, including witnesses and documents. It is your responsibility to bring the witnesses and documents you wish to present at the hearing.

Documents:

If you intend to introduce documents into evidence, **YOU MUST COMPLY WITH THE FOLLOWING REQUIREMENTS;**

All documents that you wish to present at the hearing must be paginated and must have certain information redacted. That means, that certain information must be blacked out as follows:

a. First, make a photocopy of the original document. DO NOT MARK THE ORIGINAL IN ANY WAY.
b. Secondly, if any of the following information appears on any page of the document, ***on the photocopy***, black out the following information using a black marker:
   (1) Date of birth
   (2) Mother's maiden name
   (3) Motor vehicle operator's license number
   (4) Social Security Number
   (5) Other government-issued identification number
   (6) Health insurance identification number
   (7) Financial account number
   (8) Security code or personal identification number (PIN)
c. Next, paginate each document in the lower right hand corner of each page ***of the redacted photocopy***.
d. Finally, any documentation offered into evidence must be accompanied by (9) photocopies **of the redacted and paginated copy** to provide to the Board and the Department at the hearing.
e. Please note: you must also bring the original to the hearing.

Failure to Appear:

If you fail to appear at the hearing, upon proof that due notice was served upon you to appear, the Board may proceed in the same manner as though you were present in person

The Board may hold a fact-finding meeting immediately following the close of the record.

Documents submitted in support of any Summary Suspension Motion granted in this matter are on file and available to the parties at the Department of Public Health, Public Health Hearing Office, 410 Capitol Avenue, MS #13PHO, P.O. Box 340308, Hartford, Connecticut 06134-0308 and can be obtained by contacting Jeffrey A. Kardys at 860-509-7648.

ORDER Re: Filings

The Department and Respondent are hereby ordered when submitting any pleadings, documents, motions or other papers to the Board to file an original plus two (2) copies with Jeffrey A. Kardys, agent of the Board and custodian of the record, at the address above.

Any request for a continuance of a scheduled hearing shall be made in writing not less than five (5) business days prior to the hearing date and shall state the specific grounds for the requested continuance. All such requests shall include a statement by the moving party that (1) he or she has inquired of the opposing party and there is agreement or objection to the request or that (2) despite diligent effort, he or she cannot determine the opposing party's position on the request.

The presiding officer or panel shall determine whether a continuance is granted or denied. In ruling on a motion for continuance, the following principles will guide the decision. Continuances will be granted only for good cause. **Any request for continuance made less than five (5) business days prior to the hearing date shall be granted only for extraordinary reasons which the party making the request could not reasonably have known about earlier.** The agreement of the parties to a proposed Consent Order shall not be automatic grounds for a continuance. Parties are expected to notify the Board immediately that they have agreed to a proposed Consent Order. Parties should make every effort to make such notification no less than five (5) business days before a scheduled hearing date.

The parties are encouraged to stipulate to facts which are not in dispute in order to narrow the issues to be considered by the hearing panel and to promote the timely resolution of cases. The parties may file, not less than seven (7) days before the first scheduled hearing date, a list of stipulated facts and/or material facts which are not in dispute.

Prior to a scheduled hearing, the parties are encouraged to exchange witness lists, the curriculum vitae of any expert who may be called to testify and other documents which may be offered as evidence. If either party provides a witness list to the other party, the Board Liaison shall be provided a copy of such list.

All communications to the Board shall be submitted in this fashion. The Department or Respondent shall provide a copy of each document filed to Respondent or Department as the case may be, and certify such to the Board.

Dated at Hartford, Connecticut this 17th day of August 2010.

FOR: CONNECTICUT MEDICAL EXAMINING BOARD

BY: _____

Jeffrey A. Kardys, Administrative Hearings Specialist/Board Liaison
Department of Public Health
410 Capitol Avenue, MS #13PHO
PO Box 340308
Hartford, CT 06134-0308
Tel. (860) 509-7648 FAX (860) 509-7553

c: Panel Members - Connecticut Medical Examining Board
Henry Salton, Assistant Attorney General
Jennifer Filippone, Section Chief, Practitioner Licensing and Investigations
Matthew Antonetti, Principal Attorney, Legal Office, Department of Public Health
David Tilles, Staff Attorney, Department of Public Health

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE SYSTEMS BRANCH
CONNECTICUT MEDICAL EXAMINING BOARD

In re: Gerson Sternstein, M.D.
Petition No. 2009-200921 (2009-0115-001-009)

SUMMARY SUSPENSION ORDER

WHEREAS, the affidavits, duly verified, allege facts which show violations of §20-13c of the Connecticut General Statutes, as amended, and which imperatively require emergency action in that the public health, safety or welfare of the citizens of the State of Connecticut is in clear and immediate danger; and,

Pursuant to the authority of §4-182(c) and §19a-17(c), pending the hearing set for the 27th and 31st day of AUGUST, 2010, at 9:30 a.m.

It is hereby ORDERED, by vote of the Connecticut Medical Examining Board (hereinafter "the Board") that license number 022391 of Gerson Sternstein, M.D. to practice as a physician and surgeon in the State of Connecticut is summarily suspended pending a final determination by the Board regarding the allegations contained in the Statement of Charges.

Dated at Hartford, Connecticut this 17th day of AUGUST 2010.

Anne C. Doremus, Chair
Connecticut Medical examining Board

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE SYSTEMS BRANCH
CONNECTICUT MEDICAL EXAMINING BOARD

In re: Gerson Sternstein, M.D. Petition No. 2009-200921

MOTION FOR SUMMARY SUSPENSION

The Department of Public Health (hereinafter "the Department") hereby moves in accordance with the General Statutes of Connecticut §§4-182(c) and 19a-17(c) that the Connecticut Medical Examining Board summarily suspend the license of Gerson Sternstein, M.D. to practice as a physician and surgeon in Connecticut. This motion is based on the attached Statement of Charges, Affidavits and on the Department's information and belief that the continued practice as a physician and surgeon represents a clear and immediate danger to the public health and safety.

Dated at Hartford, Connecticut this 10th day of August 2010.

Jennifer Filippone, Section Chief
Practitioner Licensing and Investigations
Healthcare Systems Branch

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
HEALTHCARE SYSTEMS BRANCH
CONNECTICUT MEDICAL EXAMINING BOARD

In re: Gerson Sternstein, M.D. Petition No. 2009-200921

STATEMENT OF CHARGES

Pursuant to the General Statutes of Connecticut, §§19a-10 and 19a-14, the Department of Public Health (hereinafter "the Department") brings the following charges against Gerson Sternstein, M.D.:

1. Gerson Sternstein, M.D., of Kensington, Connecticut (hereinafter "respondent") is, and has been at all times referenced in this Statement of Charges, the holder of Connecticut physician and surgeon license number 022391.

2. At various times in 2009 and preceding years, respondent prescribed opioids, benzodiazepines, and/or other controlled substances to patients K.R., T.P., R.O., P.P., M.D., D.T.-W., L.W., K.O'C., P.B., and S.B. Respondent's care for one or more of these patients deviated from the standard of care in one or more of the following ways:

   a. his documentation was inadequate;
   b. he made inadequate examinations and/or assessments initially and/or at appropriate interim intervals;
   c. he failed to monitor response to treatment and/or compliance with medication regimens, or monitored inadequately;
   d. he initiated and/or continued prescriptions of controlled substances in spite of contraindicating laboratory studies;
   e. he failed to inform, or adequately inform, said patient(s) of risks inherent in the prescribed controlled substances;
   f. he prescribed dangerous combinations of drugs;
   g. he prescribed inappropriate combinations of drugs;
   h. he prescribed excessive doses of opioids;
   i. he initiated, continued, and/or increased dosing of opioids in spite of signs of abuse or criminal behavior by the patient relating to the prescriptions; and/or

i. he failed to coordinate prescribing with other providers, including but not limited to dentists, orthopedists, and primary care physicians.

3. The above described facts constitute grounds for disciplinary action pursuant to the General Statutes of Connecticut, §20-13c, including but not limited to:

a. §20-13c(4); and/or
b. §20-13c(5).

THEREFORE, the Department prays that:

The Connecticut Medical Examining Board, as authorized in §§19a-17 and 20-13c, revoke or order other disciplinary action against the physician and surgeon license of Gerson Sternstein, M.D. as it deems appropriate and consistent with law.

Dated at Hartford, Connecticut this 10th day of August 2010.

Jennifer Filippone

Jennifer Filippone, Section Chief
Practitioner Licensing and Investigations
Healthcare Systems Branch

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INDEX

Eight Recurrent Deviations From Standard of Care

Name	Inadequate Documentation	Inadequate Exam/Assessment	Inadequate Monitoring	Contraindicating Labs
(KR)	yes	yes	yes	yes
(TP)	yes	yes	yes	yes
(RO)	yes	yes	yes	yes
(PP)	yes	yes	yes	yes
(MD)	yes	yes	yes	no
(DT-W)	yes	yes	yes	yes
(LW)	yes	yes	yes	no
(KOC)	yes	yes	yes	yes
(PB)	yes	yes	yes	no
(SB)	yes	yes	yes	no

Name	Did Not Inform Patient of Risks	Dangerous or Ineffective Drug Combinations	Excessive Doses of Opioids	Ignored Signs of Abuse
(KR)	yes	yes	yes	yes
(TP)	yes	yes	yes	yes
(RO)	yes	yes	yes	yes
(PP)	yes	yes	yes	yes
(MD)	yes	no	yes	yes
(DT-W)	yes	yes	yes	yes
(LW)	yes	no	yes	yes
(KOC)	yes	yes	yes	yes
(PB)	yes	no	yes	no
(SB)	yes	no	yes	no

CERTIFICATION

I, RoseMarie Deschenes, APRN, Practitioner Licensing and Investigations Section, Department of Public Health, being duly sworn, hereby attest that I have prepared and reviewed this report and it is a true, complete and accurate documentation of my investigation of Gerson M. Sternstein, MD, professional license number: 001-022391.

RoseMarie Deschenes, APRN
Department of Public Health
Practitioner Licensing and Investigations Section

Subscribed and sworn to before me this 20th day of July 2010.

Notary Public
My Commission Expires 03/31/2015

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TABLE OF CONTENTS TO EXHIBIT B (Investigation Report)

State of Connecticut
Department of Public Health
Practitioner Licensing and Investigations Section

July 20, 2010

Petition Number: 2009-0115-001-009
2009-200921

Category: Incompetence/Neglect

Respondent's Name and Address:

Gerson M. Sternstein, MD
Paragon Behavioral Health, L.L.C.
26 Chamberlain Highway
Berlin, CT 06037

Petitioner's Name and Address:

John Gadea, Jr., Director, Drug Control
Department of Consumer Protection
165 Capitol Avenue, Room 145
Hartford, CT 06106

Licensure Information

License Number: 001-022391
Expiration Date: 09/30/2010
Date Investigation was opened: January 21, 2009

Investigated by: RoseMarie Deschenes, APRN, Nurse Consultant

Allegation:

1. The Respondent, a physician, inappropriately prescribed Scheduled II controlled narcotics in large amounts and high doses without a treatment plan and stated objectives.
2. The Respondent inappropriately prescribed Scheduled II controlled narcotics for dental procedures without consulting with the client's dentist.
3. The Respondent wrote numerous duplicate Scheduled II controlled narcotic prescriptions without adequate monitoring, which resulted in his clients utilizing multiple pharmacies and multiple insurances to obtain their prescriptions.
4. The Respondent prescribed Suboxone in combination with other opioid medications.

Introduction:

The Department received a referral from the Department of Consumer Protection, Drug Control Division (DCD), regarding the Respondent's prescribing practice based in part on the numerous complaints received from his patients' concerned family members, area physicians and pharmacists regarding the strength and number of scheduled II controlled substances prescribed by the Respondent. The pharmacists identified that in several conversations they had held with the Respondent, they voiced their concerns that he, as a psychiatrist, was prescribing pain medications for pain associated with dental procedures.

DCD conducted a pharmacy search through their Prescription Monitoring Program (PMP) and reviewed the Respondent's prescriptions per patient. The Respondent's prescribing history was compared with other practitioners, including those practitioners in area hospitals. Concerns were raised when the prescriptions per patient written by the Respondent far exceeded the total number of scheduled II controlled prescriptions written per patient by all physicians practicing at Yale-New Haven Hospital.

DCD further identified that all physicians have access to this PMP and identified that the Respondent was one of the first physicians to request and acquire this access. The PMP access allows physicians to monitor their patients' controlled prescriptions (Exhibit A).

Interviews:

Numerous telephone calls and emails were conducted as well as onsite visits with the Drug Control Agents from March 12, 2009 through May 19, 2010. The purpose of all calls, emails and onsite visits was to obtain additional information, to clarify information obtained and to additional information regarding the complaint. A telephone interview was conducted on May 18, 2009 with the Respondent for the purpose of requesting an extension regarding submitting his office records. A telephone interview was conducted on October 29, 2009 with the Respondent for the purpose of explaining his rationale for switching laboratory services regarding the urine toxicology screens.
A telephone interview was conducted on September 16, 2009 with the daughter of PB & SB for the purpose of arranging an interview at the Department. An interview was conducted at the Department on September 21, 2009 with the daughter of PB & SB for the purpose of obtaining a sworn statement. Subsequent telephone interviews were conducted on October 7 and 14, 2009 to clarify information and to obtain new information (the death of her father, SB).
A telephone interview was conducted on January 26, 2010 with the police officer that responded to the 911 calls identifying that PB was found unresponsive on November 28, 2008 and SB was found unresponsive on October 13, 2009. The police officer hand delivered his report to the Department on January 26, 2010.

Exhibits:

- **A. The finalized copy of the DCD report was received on August 18, 2009 from DCD with additional information received until May 19, 2010 (Exhibit A).**
  - a. The DCD report identified the following:
    - i. The Respondent is a psychiatrist who specializes in pain management and is the sole physician in his private practice, Paragon Behavioral Health.
      1. According to DCD and the Drug Enforcement Administration (DEA) records, the Respondent surrendered his state controlled substance registration and federal DEA registration on May 9, 1988 for maintaining drug addicts by writing Schedule II controlled substance prescriptions.
         a. His privilege to prescribed Schedule II controlled substances was reinstated on May 9, 1993.
    - ii. DCD identified that it received numerous calls of complaint regarding the Respondent's prescribing practices from family members, physicians, professionals at other state agencies and pharmacists.
      1. Many of the calls were placed anonymously and the callers refused to identify themselves or to provide written statements.
      2. The Berlin Police Department reported several untimely deaths to DCD regarding individuals who had been clients of the Respondent during this time frame.
         a. A copy of their report regarding the untimely death of Patient I, PB, was provided to DCD.
    - iii. DCD identified that the State of Connecticut began a Prescription Monitoring Program (PMP) on July 1, 2008. All pharmacies were required to report the data concerning controlled drug prescriptions to the State.
      1. From this data, DCD identified that the Respondent was the number one prescriber of controlled drug prescriptions in the state from July 6, 2008 to August 6, 2009.
         a. The Respondent authorized the use of 2,442,520 controlled doses for 1,496 different clients. This averaged out to 16 prescriptions per client.

i. Yale New Haven Hospital was third on the list with 1,759,740 controlled drug doses for 20,689 different clients. This averaged out to 8 prescriptions per client.

B. A copy of the Connecticut Medical Examining Board (CMEB) statement on the use of controlled substances for the treatment of pain was obtained from the Department's website on January 21, 2009 (Exhibit B).

C. A written statement and partial copies of the Respondent's office records was hand delivered on February 25, 2009 by the Respondent (Exhibit C). (Copies of his office records are located in Exhibits D-M).

a. The Respondent's written statement identified the following:

i. He transcribed several medical records but could not transcribe all the medical records.

ii. He identified that patients G and E (LW and MD) attended Pain Management Groups conducted by psychologist John Cline, PhD and that those notes were included.

iii. He identified that he did not obtain urine toxicology screens on patient G, LW. LW was wheel chair bound and he had little to no concerns that she was either abusing or misusing her medicines nor engaging in illicit drug use.

Patient A (KR) (51 y/o)

D. A historical outline was developed and copies of Patient's A (KR) medical records, pharmacy records and dental records were received from February 25, 2009 thru June 16, 2010 (Exhibit D).

a. The historical outline identified the following:

i. The Respondent co-signed medication evaluation notes written by another practitioner (an unlicensed practitioner) for 17 out of 29 visits from January 2008 through June 2009.

ii. KR utilized multiple pharmacies chains in different towns and multiple physicians, including the Respondent to obtain and fill his prescriptions of Schedule II controlled substances.

1. KR alternated paying for his prescriptions with cash and insurance.
2. KR called in to the Respondent's office for extra Oxycodone before and after office visits.
3. Urine toxicology screens were positive for Methadone and Morphine that were not prescribed by the Respondent.

iii. KR did not inform his dentist of the dose or amount of Scheduled II controlled substances he had been prescribed by the Respondent.

iv. The Respondent wrote new prescriptions prior to the old prescriptions expiring.

b. The medical records (Respondent's office records) from January 2008 through September 2009 identified the following:

i. The medical record identified that KR had diagnoses that included Depression, Pain Disorder and a history of drug and alcohol addiction.

1. In 2006 he underwent a C5-C7 fusion.
2. A February 2009 MRI of the spine identified mild spondylosis at C4-C6.
3. A May 2009 Electromyography Report for bilateral arm numbness (SPECT) was conducted with subsequent bilateral surgery for carpel tunnel.

ii. The dose of Oxycodone increased from 570mg/24 to 1000mg/24 in addition to Suboxone (later discontinued), Skelaxin, Provigil, Lyrica and Amrix during this time period.

iii. Amrix 30mg PRN/HS was added and Oxycodone was increased (up to 600mg PRN) for dental work conducted in February 2008. Oxycodone was not decreased after the dental work was completed in March 2008.
iv. KR called in for additional Oxycodone in February, June through October of 2008 and in January 2009.
v. Positive urine toxicology results for Methadone were identified on March 13, 2008 and September 17, 2009.
    1. Positive results for Morphine were identified on November 6, 2008.
vi. A prescription written on September 4, 2008 for Oxycodone 15mg (60), prescriptions written on December 11, 2008 for Oxycodone 30mg (60), Oxycodone 30mg (15), two prescriptions written on March 19, 2009 for Lyrica 50mg (90), and two prescriptions written on May 21, 2009 for Lyrica 75mg (30) and Lyrica 50mg (90) were not identified as being filled in the pharmacy search.

c. The pharmacy records from January 2008 through April 2010 identified the following:

i. The address on record identified that KR lived in Rocky Hill, CT. As of May 2010 the address on record is identified as East Hartford and is the same address as Patient D (PBP).
ii. KR utilized several different pharmacy chains in several towns (Hartford, Kensington, Berlin, Wethersfield, Newington and Glastonbury).
iii. KR alternated paying for his prescriptions between cash and insurance.
iv. There were no providers or prescriptions listed for Methadone or Morphine.
v. The prescription for Oxycodone 30mg (25) for one day written by the Respondent on March 17, 2009 had a note that identified, "Maximum 30 tablets daily".
vi. The prescription for Oxycodone 30mg (90) for 3 days written by the Respondent on March 25, 2009 and filled on March 27, 2009 had a note that identified, "New injury at work at the C3-C4 level, Diagnosis of degenerative disc disease, S/P Cervical spine fusion C5-7, Maximum 30 tablets daily".
    1. The same note was identified on a prescription for Oxycodone 30mg (210) written by the Respondent on March 19, 2009 and filled on March 19, 2009.
    2. Of note both were filled at a different pharmacy chain and in a different town than all the other prescriptions and was never utilized again.
vii. The medical record lacked documentation for the following prescriptions written by the Respondent that were presented to the Walgreens pharmacy but not filled by KR:
    1. February 14, 2008 = Oxycodone 15mg (100) for 15 days.
    2. February 27, 2008 = Provigil 200mg (60) for 30 days.
viii. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by KR:
    1. Oxycodone 30mg 2 tablets QID (60) written on December 11, 2008.
    2. Oxycodone 30mg 5 tablets every four hours PRN, written on December 11, 2008.
    3. Lyrica 50mg TID (90) written on March 19, 2009. Only one of the possible three refills was identified as being filled.
    4. Lyrica 50mg TID (90) written on May 21, 2009. Only one of the possible three refills was identified as being filled.
    5. Lyrica 75mg every night (QHS) written on May 21, 2009. Only one of the possible three refills was identified as being filled.

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to

insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

ix. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by KR:
    1. Provigil 200mg (60) for 30 days.
        a. February 27, 2008.
        b. June 11, 2008.
        c. July 10, 2008.
        d. August 14, 2008.
        e. September 20, 2008.
        f. October 23, 2008.
        g. November 26, 2008.
        h. December 30, 2008.
    2. Oxycodone 30mg (120) for 6 days.
        a. July 3, 2008.
    3. Oxycodone 15mg (60) for 7 days.
        a. September 4, 2008.
        b. September 11, 2008.
        c. October 30, 2008.
    4. Oxycodone 30mg (30) for one day.
        a. July 7, 2009.
    5. Oxycodone 30mg (150) for 7 days.
        a. October 30, 2008.

d. The dental records identified the following:

i. From January 24, 2008 through June 1, 2009, KR underwent dental surgery and osseous graft for furcation in both is upper and lower quadrants.

ii. KR's dentist did not prescribe additional pain medications because he felt it would not be beneficial and may be toxic.

e. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The low level of morphine identified in the urine toxicology screens for narcotics is more consistent with diet (poppy seed bagels, Danish, etc.) causing a false positive.

ii. KR did acknowledge that he had taken Methadone on two occasions out of desperation when his medication regimen was not sufficient.
    1. The Respondent identified that although he did not condone this behavior, he felt it was not "nefarious".

iii. The Respondent initially prescribed Suboxone in an effort to taper his medication in anticipation of oral surgery.
    1. KR's Oxycodone dosage was reduced by 200mg in January 2008 and after the surgery the Oxycodone dosage was brought back to 600mg.
    2. There were no further increases in his dosage until October – November 2008 when KR re-experienced symptoms of renewed cervical disc problems.
    3. In March 2009, his dosage of Oxycodone was increased after KR suffered an injury at work.
    4. KR underwent bilateral carpel tunnel surgery in November – December 2009.

iv. The Respondent prescribed Provigil because KR worked second and third shifts and had complained of persistent fatique/anergia.
    1. The Respondent further identified that Provigil is a schedule IV drug and can be called into pharmacies without the need of a hardcopy prescription.
    2. The Respondent identified that regarding prescriptions not identified in the medical record, he had postdated prescriptions according to DEA regulations and had left some out.

v. The Respondent did not contact KR's oral surgeon because he felt that KR would report his medications to the oral surgeon.

vi. With regards to the issue of writing prescriptions to a patient who does not fill them, the Respondent identified the following:
    1. This indicates that the patient does not display escalated, out of control medication consumption that would reflect perpetuating a "habitual addition".
    2. KR's urine toxicology screens showed the presence of the prescribed medications.
    3. The Respondent identified that he is not aware of any mandate for physicians that prescribe scheduled or unscheduled medications to track when and where they are filled.
    4. He further identified that censuring physicians for not using the PMP program is a concern that has been raised by pain management physicians.

f. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient KR in the following areas:

Professional Ethics:

1. Writing prescriptions based on the notes of an unlicensed practitioner.
    a. The Respondent co-signed the clinical notes of other unlicensed practitioners and prescribed medications based upon these visits without completing his own documented evaluation on numerous occasions.
    b. The Consultant opined that this is a moderate deviation from the standard of care and identified in her review of the literature, that this may indicate professional misconduct.

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, there is no objective assessment noted and the care appears to be driven by patient request.

i. The Consultant further identified that it was not possible to determine from reading the entries noted in the medical record what the exact prescribed therapy is or how it relates to the patient's self report.

c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Prescribing potentially lethal doses of opiates without an assessment for suicide risk to a patient with multiple risk factors.
    a. The Consultant identified that it is the community standard of care to assess a patient's risk for suicide when they present with multiple risk factors.
    b. The Consultant opined that the Respondent's failure to assess is a serious deviation from the standard of care as the potential for a lethal outcome is high.
2. Prescribing pain medications for dental procedures without consulting with KR's dentist.
    a. The Consultant identified that the community standard is to coordinate treatment if both the dentist and physician may be prescribing controlled substances.
    b. The Consultant opined that the Respondent's failure to communicate with KR's dentist is a severe deviation of the standard of care due to the high risk of addictive opiate toxicity and the dentist's documented concern of lethal toxicity.
3. Failure to utilize information available from specialists and objectives tests, such as MRI and urine toxicology, in guiding the treatment plan for KR.
    a. The Respondent does not appear to communicate with the other community physicians treating KR.
        i. The Consultant identified that the Respondent seems unaware that KR is filling prescriptions for benzodiazepines, Lexapro and Chantix written by another physician.
    b. The Consultant opined that the Respondent's lack of communication and coordination with community physicians is a moderate deviation from the standard of care as it placed KR at greater risk than average from respiratory depression and death due to the high dosage of opiates prescribed by the Respondent.
        i. The Consultant opined it is especially important to communicate the dosage of medications when a patient is scheduled to have surgery in order to avoid surgical complications.
4. Failure to assess the patient's response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.

b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to KR.
    i. The Consultant identified that the Respondent continued to prescribe high doses of schedule II controlled substances despite specialist consultation and objective data that identified that the patient's pain had improved pain and physical function secondary to traction and surgery.
    ii. The Consultant identified that urine toxicology screens tested positive for opiates (Methadone) not prescribed by the Respondent may indicate that KR is misusing and diverting his medications for profit.
c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of KR's increasing dependence on the Oxycodone over a two-year period.

Evaluation:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient with objective evidence of the patient engaging in criminal and dangerous behaviors.
    a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction.
        i. The Consultant opined that the Respondent's prescribing of multiple different controlled substances to any patient, especially one with a documented history of drug addiction is not the community standard.
            1. The Consultant identified that the use of multiple pharmacies and asking for addition prescriptions before and after office visits, indicate possible misuse and diversion for profit.
                a. The Consultant opined that a responsible practitioner would at least consider that KR was diverting some of his medications for profit.
        ii. The Consultant further identified that it is not the community standard of care to prescribe opiates with Suboxone, as drug interactions are a risk as well as the lowering of effectiveness of both drugs.
            1. The Consultant identified that in the early part of 2008, the Respondent added Suboxone to the prescriptions of Oxycodone 15mg and 30mg, Amrix 30mg, Skelaxin 800mg and Provigil 200mg.
    b. The Consultant opined that the Respondent's prescribing of Oxycodone to KR and failing to alter the treatment plan when objective evidence indicated that KR was using other opiates is a severe disservice to this patient and a severe deviation from the standard of care.

Prescribing practices:

1. Failure to address tolerance and potential lethal toxicity with the patient while prescribing excessively high doses and in increasing amounts of Oxycodone.
    a. The Consultant identified that it is the community standard to prescribe much lower doses of medication and for a defined length of time for acute injuries, especially when the patient has had a positive response to definitive treatment like surgery.
        i. The Consultant identified that the usual starting dose of Oxycodone is 5-15mg every four to six hours. This dosage averages out to 90mg per day, which is in stark contrast to the 1000mg per day the Respondent prescribes for KR.
            1. The Consultant further identified that in August 2007, the Respondent prescribed a daily dose of 540mg of Oxycodone (Morphine equivalent is 270mg/24), which, exceeds the absolute maximum of 180mg of Morphine equivalent per day.
            2. By June of 2009, the Respondent prescribed a daily average of 1000mg (30,000mg for the total month).
        ii. The Consultant identified that in her review of the literature, she found that for chronic musculoskeletal pain, daily doses above 180mg of morphine or its equivalent have not been validated in clinical trials.
    b. The Consultant opined that the Respondent's prescribing practices is a serious deviation from the standard of care.

Patient B (TP) (31 y/o)

E. A historical outline was developed and copies of Patient's B (TP) medical records and pharmacy records were received from February 25, 2009 thru June 21, 2010 (Exhibit E).

a. The historical outline identified the following:

i. The Respondent co-signed medication evaluation notes written by another practitioner (an unlicensed practitioner) for 13 out of 18 visits from August 2008 through June 2009.
ii. TP was on probation and used multiple pharmacies in different towns and multiple physicians including the Respondent to fill his schedule II controlled substances.
iii. TP was prescribed Motric and Percocet by Dr. Gary Schector until March 2009.
iv. The Respondent does not address urine toxicology screens that were positive for narcotics not prescribed by him.
v. The Respondent prescribed Suboxone with Percocet and Oxycodone and renewed prescriptions before old prescriptions expire.

b. The medical records (Respondent's office records) from August 2008 through June 2009 identified the following:

i. The medical record identified that TP had diagnoses that included Opiate Dependence, Chronic Pain and atrial fibrillation.
    1. A December 2008 ankle x-ray identified no fracture, degenerative changes.
    2. A 2006 MRI of the spine identified broad base disc bulge with extension into the left neural foramen at the L4-5 level.
ii. The patient was initially prescribed Suboxone 32mg.
iii. Ativan and Rozerem were added in November 2008.

iv. In February 2009, records were obtained from Dr. Gary Schecter.
    1. At this time, in addition to the Suboxone, Oxycontin 160mg/24 was added and increased to 240mg/24 by May of 2009.
v. Dr. Schecter wrote a letter dated March 11, 2009 identifying that he was turning over the pain management to the Respondent's services.
vi. Lyrica 150mg/24 was added in April 2009 and increased to 225mg/24 in May 2009.
vii. A letter to the patient's probation officer was sent on April 27, 2009 indicating that TP was compliant with his medication regime.
viii. Percocet 100mg/24 was added in May 2009.
ix. The Respondent provided double prescriptions to the patient beginning in May 2009.
x. From August 2008 through March 2009, TP tested positive for Codeine, Morphine, Oxycodone & Opiates, which were not prescribed by the Respondent.

c. The pharmacy records from August 2008 through March 2010 identified the following:

i. The address on record identified that TP lived in Bristol, CT.
ii. TP continued to fill prescriptions for Vicodin, Percocet & Oxycontin from Dr. Gary Schecter and Dr. Luis Serazo until May 2009.
    1. These prescriptions were filled while the Respondent was still prescribing Suboxone.
iii. TP utilized several different pharmacies in different towns to fill these prescriptions (Bristol, New Britain, Southington, and Terryville).
    1. Although Dr. Schecter wrote a letter dated March 11, 2009 identifying that he was turning over the pain management to Dr. Sternstein's services, TP filled a prescription of Oxycontin 15mg (42) on May 8, 2009 written by Dr. Schecter.
iv. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by TP:
    1. Suboxone 8.64mg/2.44mg (60) for 15 days:
        a. December 31, 2008.
        b. March 11, 2009.
        c. March 25, 2009.
v. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by TP:
    1. Ativan 1mg (30) with one refill written on:
        a. September 4, 2008.
        b. January 14, 2009 (only one prescription was identified as being filled).
        c. February 25, 2009 (both were not filled).
        d. April 27, 2009 (only one prescription was identified as being filled).
    2. Lyrica 75mg TID (90) written on May 11, 2009.

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

vi. The Respondent wrote a prescription for Suboxone 8.64mg/2.44mg (60) for 15 days on August 3, 2009 with a note that identified, "Pt with chronic pain".

vii. The Respondent wrote a prescription for Percocet 10mg/325mg (150) for 15 days on August 31, 2009 with a note that identified, "Maximum 10 tablets daily".

d. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. TP had a diagnosis of lumbar radiculopathy, atrial fibrillation, opioid dependence and panic disorder. TP was referred to the Respondent for the following reasons:
   1. The Respondent was to take over writing the Suboxone prescriptions.
   2. The Respondent was on TP's insurance plan.
   3. The Respondent had experience with pain management.

ii. The Respondent identified that TP understood that the only prescriptions that would be written would be for Suboxone initially.
   1. The Respondent identified that there is growing literature on Suboxone's efficacy and advantages in the management of chronic pain in conjunction with other opioids.

iii. The Respondent identified that when he took over prescribing TP's analgesics in March 2009, TP had been receiving 240mg of Oxycodone a day in the form of immediate and sustained release preparations.
   1. The Respondent further identified that he merely continued this practice in the form of Oxycodone 80mg sustained release tablets three times a day with the use of Percocet for breakthrough pain.
      a. The Respondent denied that he rapidly increased the dosage of TP's Oxycodone.

iv. The Respondent identified that he prescribed Lyrica 50mg up to 3 times per day for 5 weeks and then 75mg up to 3 times a day.
   1. The Respondent identified that TP was using less that what he had prescribed because he would notice heart palpations.

v. The Respondent identified that TP did keep him informed of his emergency room (ER) visits and prescriptions obtained by other practitioners, which is why the Respondent felt comfortable writing a letter to his probation officer that he was compliant with treatment.

vi. There were no office notes for the December 31, 2008 and March 25, 2009 Suboxone prescriptions because TP only came in to submit a urine and pick up his prescriptions; therefore, no office notes were necessary.

vii. The Respondent identified he had no records of writing a prescription for Ativan in February 2009.

e. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient TP in the following areas:

Professional Ethics:

1. Writing prescriptions based on the notes of an unlicensed practitioner.
   a. The Respondent co-signed the clinical notes of other unlicensed practitioners and prescribed medications based upon these visits without completing his own documented evaluation on numerous occasions.
   b. The Consultant opined that this is a moderate deviation from the standard of care and identified that in her review of the literature, that this may indicate professional misconduct.

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, there is no objective assessment noted and the care appears to be driven by patient request.
        i. The medical record identified that the Respondent's notes were extremely brief, did not indicate a physical exam and rarely indicated a mental status exam or an observation of the patient's condition and behavior.
    c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the patient's response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
    b. The Consultant identified that the Respondent's documentation failed to identify that he providee alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to TP.
        i. There is no objective or even structured subjective evaluations of physical limitation or assessments of the patient's response to treatment documented in the medical record.
    c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of TP's increasing dependence on opioid medication.
2. Prescribing pain medications for dental procedures without consulting with TP's dentist.
    a. The Consultant identified that the community standard is to coordinate treatment if both the dentist and physician may be prescribing controlled substances.

b. The Consultant opined that the Respondent's failure to communicate with TP's dentist is a severe deviation of the standard of care due to the high risk of addictive opiate toxicity.

Evaluation:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient with objective evidence of the patient engaging in criminal and dangerous behaviors.
    a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction.
        i. The Consultant identified that it is the community standard to ensure such patient is not misusing his medications or engaging in further criminal conduct.
            1. The medical records identified that TP was looking for a cheaper Suboxone and according to the Consultant should have been a red flag for possible misuse and abuse of the drug by TP.
        ii. The Consultant further identified that the Respondent never indicated he had any knowledge that TP is using multiple pharmacies and multiple physicians for scheduled II medications.
            1. The medical record review identified that the Respondent did not address urine toxicology screens positive for narcotics not prescribed by him.
    b. The Consultant opined that the Respondent's prescribing of schedule II medications to TP and failing to alter the patient's treatment plan when objective evidence indicated that TP was using other opiates is a severe disservice to this patient and a severe deviation from the standard of care.

Prescribing Practices:

1. Failure to address tolerance and potential lethal toxicity with the patient while prescribing excessively high doses of opioid medication and prescribing combinations of opioid medications and Suboxone.
    a. The Consultant identified that it is the community standard to prescribe much lower doses of medication and for a defined length of time.
        i. The Consultant identified that for the month of July 2009, the Respondent prescribed exceedingly high doses of Percocet 10/325mg, Oxycodone 300mg/24 (equivalent to Morphine 150mg/24), Lyrica 75mg (90 tablets for the month), Oxycontin 240mg/24 (equivalent to Morphine 120mg/24) and Suboxone 8.64/2.44mg (120 tablets for the month).
    b. The Consultant opined that it is substandard care to prescribe schedule II controlled medications for unclear indications.
        i. The Consultant further identified that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.
2. Prescribing Suboxone to this patient who is dependent on opiate agonists.

a. The Consultant opined that it is not the community standard of care to prescribe opiates with Suboxone, as drug interactions are a risk as well as the lowering of the effectiveness of both drugs.
    i. She further opined that serious withdrawal symptoms could emerge as well as increased risk of opiate abuse.

3. Prescribing the maximum dose of Suboxone to TP without any objective evidence documented in the medical record for the maximum dose and in combination with opiate medications.
    a. The Consultant opined that this is not the standard of care and identified that in her review of the literature, the administration of Buprenorphine should be discontinued if the patient is also taking opioid medications.
    b. The Consultant identified that it is the community standard to stabilize a patient on a daily dose of 16/4mg to 24/6mg instead of the maximum dose of 32/8mg as prescribed by the Respondent.
4. Prescribing Lorazepam to TP for unclear and undocumented indications in combination with opioid medications and Suboxone.
    a. The Consultant opined that the Respondent did not meet the community standard and identified that in her review of the literature, the use of sedative-hypnotics like benzodiazepine, Lorazepam, with Suboxone and opiates are contraindicated due to risk of death.

Patient C (RO) (46 y/o)

F. A historical outline was developed and copies of Patient's C (RO) medical records and pharmacy records were received from February 25, 2009 thru June16, 2010 (Exhibit F).

a. The historical outline identified the following:

i. The DCD report had identified that RO was paying $1000 in cash every two weeks for the prescriptions he obtained from the Respondent.
ii. The Wal-Mart pharmacy search for the period of May 2008 through July 2009 identified that RO paid $19,520.71 in cash for schedule II controlled medications prescribed by the Respondent.
iii. The Beacon Pharmacy search for the period of August 2008 through July 2009 identified that RO paid $10,134.40 in cash for schedule II controlled medications prescribed by the Respondent.
iv. The Walgreens pharmacy search for the period of January 2008 through July 2009 identified that RO paid $22,985.14 in cash for schedule II controlled medications prescribed by the Respondent.
v. The Respondent wrote duplicate prescriptions one to two days apart.
vi. From September 11, 2008 through September 16, 2008, RO went to four different pharmacy chains in three different towns to fill two prescriptions of Percocet 5/325mg (360) and four prescriptions of Oxycontin 40mg (170).
    1. The same pattern of utilizing different pharmacy chains in different towns continues through July 2009.

b. The medical records (Respondent's office records) from January 2008 through May 2009 identified the following:

i. The medical records identified that RO had diagnoses that included Depression, Pain Disorder and a history of herniated disc at the level of L5-S1.
    1. In 1997, RO was involved in a motor vehicle accident (MVA).

2. In 1993, RO had a fusion at the L5-S1 level.
3. In 1990, RO sustained a work related injury.

ii. From January 2008 through May 21, 2009, only the Respondent evaluates RO and the Respondent's notes are typed.

iii. The Respondent prescribed Oxycontin 400mg/24 in January 2008, which was increased to 720mg/24 by July 2009.

iv. The Respondent also consistently prescribed Percocet 50mg/24 during this same time period.

v. During this same time period, double prescriptions were written by the Respondent for Oxycontin 40mg and Oxycontin 80mg for one date and then a second set of prescriptions would be dated for the next day.

vi. The Respondent documented that urine toxicology screens were identified as "OK, consistent with medications" during this same time frame despite the following information:

1. RO tested positive for Benzodiazepines, Suboxone and Methadone with traces of Cocaine on April 17, 2008.
2. Alcohol was detected on the urine toxicology screen of August 14, 2008.

c. The pharmacy records from January 2008 through July 2009 identified the following:

i. The address of record identified that RO lived in New Britain, CT.

ii. RO utilized multiple pharmacy chains in several different towns to fill his schedule II controlled medications prescribed by the Respondent.

iii. RO paid $57,838.65 in cash for his schedule II controlled medications prescribed by the Respondent during this time period.

iv. On June 26, 2008 the Respondent wrote a prescription for Oxycontin 40mg (170) with a note that identified, "Increased dose-increased activity."

v. On September 11, 2008 the Respondent wrote a prescription for Oxycontin 40mg (170) for 14 days with a note that identified, "Fill early for travel."

1. The same note was written on a prescription for Oxycontin 40mg (170) dated and filled on October 30, 2008.

vi. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by RO:

1. February 6, 2008 = Oxycontin 40mg 6 tablets BID (170).
2. February 7, 2008 = Percocet 5/325mg 2 tablets every 4 hours, PRN (360).
3. February 28, 2008 = Oxycontin 40mg 6 tablets BID (170) and
    i. Percocet 5/325mg 2 tablets every 4 hours, PRN (360).
4. March 20, 2008 = Percocet 5/325mg 2 tablets every 4 hours, PRN (360) and
    i. Oxycontin 40mg 6 tablets BID (170).
5. August 14, 2008 = Oxycontin 40mg (170) for 14 days.

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

vii. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by RO:

1. August 15, 2008 = Oxycontin 40mg (170). (Only two prescriptions are recorded in the medical record and the pharmacy search identified three prescriptions presented).

d. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that RO had a diagnosis of multilevel degenerative spine disease, post laminectomy syndrome, status post spinal infusion, and recurrent major depression. The Respondent further identified that RO was opiate-tolerant.

ii. The urine toxicology screen that was positive for trace cocaine, Buprenorphine and Methadone was explained by the Respondent as having an "indicator" on the cup that had limited reliability and limited sensitivity and specificity.

1. The Respondent identified that the results from the urine screen done by Calloway Lab were not available for 5 to 7 days after the sample was collected.
    a. The confirmation of "positive" test results were available a week after the "screen" test results.
2. The indicator on the "point of service cup" is designed to alert the staff only when the results are robustly present so that they may speak to the patient at the time of the sample collection.
    a. The Respondent further identified that this was not the case with RO as all results discussed are based on the previous screen results.

iii. The Respondent identified that RO is self-employed and without health insurance due to "pre-existing conditions." He further identified that RO had difficulties coming up with the cash to pay for his prescriptions.

1. The Respondent identified that schedule II prescriptions cannot be filled in smaller allotments; therefore a new prescription is required each time.
    a. The Respondent identified that this caused much confusion when the DEA was unclear about the procedure for post-dated prescriptions.
2. The Respondent identified he agreed to write prescriptions in smaller allotments to give RO some flexibility with his finances and travel needs.
    a. The Respondent identified that the record shows that RO had to stretch what medications he received and had to suffer as a result.
    b. The Respondent identified he does not believe RO was diverting his medications as he would not have missed the opportunity to fill a prescription.
        i. As proof that RO was not diverting and opiate tolerant, the Respondent identified that in 2005, a blood level of Oxycodone was obtained that indicated the level was consistent with the dosage prescribed.

iv. The Respondent identified that the increase in opioid dose was clinically appropriate in December 2008 when RO presented with his arm in a sling.

1. The Respondent identified that RO had sustained a torn bicep tendon while attempting to move a refrigerator.
2. The Respondent further identified that he continued the increased dose of opiate medication because RO reported improved level of function and did not manifest adverse side effects on the higher dose.

e. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for RO in the following areas:

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, and the care appears to be driven by patient request.
        i. The Consultant identified that although the initial evaluation was dated July 19, 2007, the Respondent's prescription log identified that the Respondent wrote Oxycontin, Percocet, Soma and Serzone prescriptions for RO prior to July 19, 2007.
        ii. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.
    c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
    b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to RO.
        i. The Respondent's prescription log for the month of May 2007 indicates that RO was prescribed 267 tablets of Oxycontin 40mg and 360 tablets of Percocet 5/325mg without being seen by the Respondent.
    c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of RO's increasing dependence on opioid medication.

Evaluation:

1. Failure to address tolerance and potential lethal toxicity with the patient that is prescribed excessively high doses of opioid medications and prescribed in combination with antidepressants.
    a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
        i. The medical record identified that in early 2008, the Respondent was concerned about the high doses of Percocet due to toxicity and that RO identified that he had altered his medication regime on his own.
        ii. The medical record lacked evidence that the Respondent took any action to address these concerns and in June 2008, adds Ambien due to psychosocial complaints from RO.
    b. The Consultant opined that it is substandard care to prescribe schedule II controlled medications for unclear indications.
        i. The medical record identified that in December 2008, RO reported injuring himself moving a refrigerator.
            1. The Respondent failed to verify the injury and increased the dosage of opiate medication without any objective reason to support the increase.
        ii. The Consultant further identified that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.

Prescribing Practices:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient with objective evidence of the patient engaging in criminal and dangerous behaviors.
    a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior.
        i. The Consultant identified that over a two-year period, the Respondent increased the dosage of narcotics to a patient with a known history of abusing controlled substances quite dramatically.
            1. The medical record identified that the Respondent prescribed a total dose of Oxycontin that was increased from 9,600mg to 43,200mg a month.
            2. The Respondent prescribed a total dose of Percocet that was increased from 1800/117,000mg to 3600/234,000mg per month.
        ii. She further identified that is the community standard to ensure such patient is not misusing his medications or engaging in further criminal conduct.
            1. The medical record identified that RO's urine toxicology screens tested positive for Methadone that was not prescribed by the Respondent and does not appear to be addressed by the Respondent.

2. The medical record identified a continued pattern displayed by RO throughout 2008 of multiple prescriptions for Schedule II medications prescribed for vague reasons, thousands of dollars spent on these medications and prescriptions written without being filled that would indicate a possibility of misuse and/or diversion of the controlled substances.
3. The medical record identified that RO reported he was arrested on January 26, 2009 and the Consultant identified that the Respondent failed to alter his prescribing practices.

b. The Consultant opined that the Respondent's prescribing of schedule II medications to RO and failing to alter the treatment plan when objective evidence indicated that RO was using other opiates is a severe disservice to this patient and a severe deviation from the standard of care.

Patient D (PBP) (45 y/o)

G. A historical outline was developed and copies of Patient's D (PBP) medical records, dental records, and pharmacy records were received from February 25, 2009 thru June 16, 2010 (Exhibit G).

a. The historical outline identified the following:

i. The Respondent co-signed medication evaluation notes written by another practitioner (an unlicensed practitioner) for 3 out of 26 visits from January 2008 through June 2009.
ii. PBP's urine toxicology screens are diluted with multiple positive results for Cocaine.
iii. PBP utilized multiple pharmacy chains in different towns and alternated with cash and several different insurances to fill her schedule II controlled substances prescribed by the Respondent.
iv. Several prescriptions filled by PBP are not documented in the medical record.
v. The Respondent wrote pain medication prescriptions for dental procedures and failed to address the positive results for Cocaine in the urine toxicology screens in a timely manner.
vi. The Respondent wrote different diagnostic codes for the prescription Provigil (DSM IV 314.0, 307.45, and 347.0).

b. The medical records (Respondent's office records) from January 2008 through August 2009 identified the following:

i. The medical records identified that PBP had diagnoses that included Mood and Anxiety Disorder, Angina (1989 with Cocaine use) and a history of Substance abuse with Heroin and Cocaine.
    1. In July 2004 an MRI identified reversal of cervical lordosis with degenerative changes at C4-C6 with minimal foraminal stenosis.
    2. In September 2001 subsequent to a MVA in August 2001, x-rays identified degenerative changes at C3-C6 with a loss of normal cervical lordosis.
    3. In August 2001 x-rays identified shoulder instability, type II acromion.

ii. The Respondent prescribed Methadone 280mg in January 2008, which was decreased to 200mg by August 2009. In addition, the Respondent prescribed Oxycodone 480mg PRN/24 and Xanax 2mg PRN/24.
iii. In June 2008 when PBP was scheduled for dental work, the Respondent changed the Oxycodone from a four times a day PRN to every four hours PRN which allowed her to consume up to 600mg PRN/24. By December 2008, the Respondent increased the dosage to 750mg PRN/24.
iv. In December 2008 the Respondent increased the Xanax to 5mg PRN/24; however, he prescribed a quantity per prescription, which allowed PBP to take 6mg PRN/24. This prescribing practice continued through August 2009.
v. In December 2008, March and June 2009, the Respondent also prescribed Provigil 400mg/24.
vi. On January 5, 2009 the Respondent wrote an additional Oxycodone 30mg prescription for 40 pills (2 days).
vii. In January 2009 the Respondent prescribed Oxycontin 320mg/24 for dental surgery in addition to Oxycodone 750mg PRN/24, Methadone 240mg/24 and Xanax 5mg/24. The Oxycontin was not discontinued after the oral surgery.
viii. By the end of June of 2009 the Respondent wrote prescriptions that allowed PBP to consume Methadone 200mg/24, Oxycodone 750mg PRN/24, Oxycontin 320mg/24, and Xanax 6mg PRN/24.
ix. On July 28, 2009, the Respondent prescribed an additional Oxycontin 240mg for one day.
x. Urine toxicology screens tested positive for cocaine from March 19 through May 7, 2008 and again from April 22 through July 2009.
    1. The urine toxicology screens from Calloway Labs received on February 25, 2009 identified that PBP provided diluted urines on March 26, 2008, July 16, 2008 and September 10, 2008.
        a. The subpoenaed urine toxicology screens received on October 2, 2009 did not identify that the urine toxicology screen was diluted on March 26, 2008.
xi. A letter dated February 5, 2008 written by the Respondent identified that in 2006, PBP had a significant relapse with Cocaine and two positive urine toxicology screens for Cocaine in the fall of 2006.
xii. The Respondent's office notes from March 19 through May 7, 2008 and April 2009 identify that she is doing well, urine toxicology screens are satisfactory and she is attending 12 step meetings and/or not going to meetings but talking to her sponsor.
xiii. On November 12, 2008, the Respondent identified in his notes that she has remained abstinent.
xiv. On May 13, 2009, the Respondent identified in his office notes that she is stable on medications with "one slip" and on June 10, 2009, the Respondent identified that she is "struggling with sobriety".

c. The pharmacy records from January 2008 through July 2009 identified the following:

i. The addresses on record identified that PBP lived in Middletown and East Hartford, CT.
    1. As of May 2010, the address of record identified PBP lived in East Hartford and had the same address as Patient A (KR).
ii. PBP traveled to different towns to different pharmacy chains on the same day in order to fill prescriptions written by the Respondent (Cromwell, Vernon, Berlin, Wethersfield, Glastonbury, East Hartford, West Hartford and Middletown).

1. From February 24, 2009 through March 17, 2009, she traveled on 7 days to Kensington, Wethersfield, and Cromwell, back to Kensington, East Hartford, Vernon (twice on two separate days), Kensington and Berlin.
2. A total of 4 different pharmacy chains were utilized in filling her prescriptions written by the Respondent.

iii. PBP alternated paying for her medications with cash and utilized several different insurances in the same time period.
1. In 2008 before PBP became Medicaid eligible (December 2008 through March 2009), PBP paid approximately $4769 in cash for narcotic medications prescribed by the Respondent.
2. From January 2009 through August 2008, PBP paid approximately $6769 in cash for narcotic medications prescribed by the Respondent.
    a. This is during the period of Medicaid eligibility (January 2009 through March 2009) and while on CONNPACE (June 2009 through August 2009).

iv. PBP also received scheduled II narcotic medications from her dentist to treat her pain for the dental work performed.

v. On February 9, 2009, the Respondent wrote a prescription for Oxycontin 60mg 2 tablets QAM, 3 tablets QPM for 35 tablets but the pharmacy records identified that 45 tablets were filled instead of 35.

vi. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by PBP:
1. June 18, 2008 = Xanax 1mg (60).
2. July 14, 2008 = Xanax 1mg (10) for two days.
    a. The prescription was not written on the Respondent's standard taper proof prescription pad.
3. August 4, 2008 = Xanax 1mg (10) for two days.
    a. The prescription was not written on the Respondent's standard taper proof prescription pad.

vii. The pharmacy records identified that the following prescription was identified as being filled several months after it was written:
1. Provigil 200mg BID (60) with one refill dated March 18, 2009 = One prescription was filled on March 24, 2009 and the second was filled on August 6, 2009.

viii. The medical record lacked documentation for the following prescriptions written by the Respondent that were presented to Walgreens pharmacy but not filled by PBP:
1. June 11, 2008 = Methadone 10mg (170) for 7 days.

ix. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by PBP:
1. February 13, 2008 = Xanax 1mg BID, PRN (60) with one refill (only one prescription was identified as being filled).
2. July 16, 2008 = Roxycodone 30mg 4 tablets every 4 hours, PRN (130).
3. October 6, 2008 = Roxycodone 30mg 4 tablets every four hours, PRN (45).

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

x. The pharmacy records identified that on January 19, 2009, PBP filled a prescription that the Respondent wrote for Oxycontin 80mg (60) for 15 days with a note that identified, "temporary increase-oral surgery."
    1. On January 26, 2009, PBP filled a prescription that the Respondent wrote for Oxycontin 60mg 3 tablets BID (45) with a note that identified, "Status Post Oral Surgery."
    2. On January 26, 2009, PBP filled a prescription that the Respondent wrote for Methadone 10mg 6 tablets QID (147) with a note that identified, "Patient with chronic pain."

d. The dental records identified the following:

i. The dental records identified that PBP was a patient from June 16, 2008 through January 2009.
    1. PBP was examined and it was recommended that she have all her remaining maxillary teeth removed and a denture fabricated.
        a. At the patient's request, her records were sent to another dentist for a second opinion.
    2. PBP had one surgical procedure for the removal of tooth #12 and she left with a prescription for Amoxicillin and Percocet.

ii. PBP was referred to an oral surgeon who removed the remaining maxillary teeth and the dentist made an immediate denture.
    1. PBP returned on January 27, 2009 for an adjustment and the office has had no contact with her since.

e. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that PBP had a diagnosis of multilevel (C4-C7) degenerative disc disease of the cervical spine with reverse of lordosis, severe recurrent major depression, post-traumatic stress disorder, panic disorder, cocaine and opioid abuse.
    1. The Respondent further identified that PBP is clearly opioid tolerant.
    2. The Respondent identified that he prescribed Methadone 280mg daily and Oxycodone (immediate release) up to 480mg daily.

ii. Due to her significant weight gain, the Respondent identified he began the process of opioid-rotation, cross tapering the Methadone down and the Oxycodone up.
    1. He identified that a rough estimate of equianalgesic dosing suggest 40mg of Methadone may be equivalent to 80-120mg of Oxycodone.
    2. He further identified that in an ideal situation, the regime of Methadone 280mg/Oxycodone 480mg would be equivalent to Methadone 200mg/Oxycodone 640-720mg, which was the dosing regime noted in February 2009.

iii. The Respondent identified that it is clinically warranted to prescribe additional analgesics in higher that expected doses for opioid tolerant chronic pain patients because these individuals suffer a heighten sensitivity to painful stimuli.
    1. He further identified that hyperesthesia is possibly the nervous system's way of adjusting to be able to recognize new injury despite high opioid receptor occupancy with medications.
    2. The Respondent identified that PBP report improved sleep and a better ability to function early in the day, which he considers, indicates why it is clinically indicated.

iv. The Respondent identified that PBP notified him that her urine toxicology screens would be unsatisfactory as noted in his March 19, 2008 note.

1. The Respondent identified that she requested and received individual therapy to help during a stressful period.
2. The Respondent further identified that over the next 5 weeks, the urine toxicology screens were clean and remained clean for a year.

v. The Respondent identified that Provigil was prescribed to augment her antidepressant regime and because of clinical studies that suggest it may be helpful in attenuating cocaine cravings.
   1. He further identified that the clinical response to the individual who suffers from a moderate to severe chronic pain disorder and a chronic substance abuse disorder who manifests substance abuse relapses is to offer more treatment, not to punitively withhold treatment.

vi. The Respondent identified that in the eight years of treatment with him, PBP had one significant relapse in 2005 in which she entered an outpatient intensive treatment.
   1. Subsequent relapses in 2006, 2008 and 2009 were low grade and in the context of being a victim of physical and emotional abuse.
   2. Urine toxicology screens tested positive for her prescribed medications and the Respondent identified that he was not concerned about diluted screens.
      a. He further identified that he was more concern by samples that are submitted with non-physiologic temperatures.

f. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for PBP in the following areas:

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
   a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
      i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
   b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, and the care appears to be driven by patient request.
      i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.
   c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
   a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
   b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to PBP.
      i. The Consultant identified that instead, the Respondent prescribed large doses of opiate medication to treat non-specific pain that had been demonstrated by specialist consultation and objective testing to require interventions such as physical therapy rather than the use of controlled substances.
   c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of PBP's increasing dependence on opioid medication.
2. Prescribing pain medications for dental procedures without consulting with PBP's dentist.
   a. The Consultant identified that the community standard is to coordinate treatment if both the dentist and physician may be prescribing controlled substances.
   b. The Consultant opined that the Respondent's failure to communicate with PBP's dentist is a severe deviation of the standard of care due to the high risk of addictive opiate toxicity.

Evaluation:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient with objective evidence of cocaine use.
   a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior.
      i. She further identified that is the community standard to ensure such patient is not misusing their medications or engaging in further criminal conduct.
         1. The patient's report of a long history of drug abuse, urine toxicology screens that were diluted and tested positive for Cocaine throughout the time period reviewed along with a conviction of assault and paraphernalia should have aroused suspicion of medication misuse according to the Consultant.
         2. In addition, the Consultant identified that the use of large sums of cash, utilizing different pharmacy chains in different towns along with multiple insurances, were all indicators that PBP was possibly misusing and abusing the prescribed medications.

ii. She identified that the Respondent never addressed the possibly that PBP may be misusing her prescriptions and despite evidence of medication misuse. The Respondent believes that PBP is using her medications appropriately.

b. The Consultant opined that the Respondent's prescribing of schedule II medications to PBP and failing to alter the treatment plan when objective evidence indicated that PBP was using Cocaine is a severe disservice to this patient and a severe deviation from the standard of care.

Prescribing Practices:

1. Failure to address tolerance and potential lethal toxicity with the patient that is prescribed excessively high doses of opioid medications and prescribed in combination with Xanax, Lamictal and Provigil.
   a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
      i. The Consultant identified that for the month of June 2009, the Respondent prescribed high doses of Methadone, Oxycontin, Roxycodone, Xanax, Lamictal and Provigil without objective evidence of their need and with objective evidence to the contrary.
      ii. The Consultant further identified that the doses were so large that death could occur from respiratory depression and coma.
   b. The Consultant opined that it is substandard care to prescribe schedule II controlled medications to a patient with a known substance abuse history for unclear indications.
      i. The Consultant opined that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.
      ii. The Consultant identified that in the literature she reviewed, the use of opioid medications was identified as mostly for acute monophasic pain and not for non-cancer or non-progressive chronic pain syndromes.

Patient E (MD) (50 y/o)

H. A historical outline was developed and copies of Patient's E (MD) medical records and pharmacy records were received from February 25, 2009 thru June 21, 2010 (Exhibit H).

a. The historical outline identified the following:

i. The Respondent co-signed medication evaluation notes written by another practitioner (an unlicensed practitioner) for 15 out of 17 visits from January 2008 through May 2009.
ii. The Respondent prescribed Methadone and Fentanyl patches with Oxycontin.
iii. The Respondent failed to address illicit drugs or negative drug levels for prescribed medications identified in the urine toxicology screens.
iv. MD attended a pain management group not conducted by the Respondent.
v. MD utilized multiple pharmacy chains in different towns and paid for prescriptions with different insurances and/or cash.

b. The medical records (Respondent's office records) from January 2008 through May 2009 identified the following:

i. The medical records identified that MD had diagnosis that included Major Depression, Pain Disorder and Hepatitis.
   1. In March 2009 a police report identified that scheduled II controlled prescriptions and jewelry were stolen at MD's home.
   2. In January 2009 a police report identified that scheduled II controlled prescriptions and jewelry were stolen at MD's home.
   3. A deposition in February 2009 identified that MD had a knee operation in 2004 from a MVA in 2001.
   4. In 2001 MD was diagnosed with right shoulder girdle myofascial pain and left thoracic outlet syndrome.

ii. The Respondent wrote prescriptions for Fentanyl 200mcg every three days, which alternated with Methadone 120mg/24 in January 2008. In addition, Oxycontin 900mg/24 and Oxycodone 240mg /24 was also prescribed.

iii. In September 2008 prescriptions for the Fentanyl and Methadone were written on the same day.

iv. By January 2009 the Respondent wrote prescriptions for Fentanyl 200mcg every three days, Methadone 120mg/24, Oxycontin 1140mg/24 and Oxycodone 210mg/24.

v. The medical record identified that MD reported having his medications stolen when his house was robbed in January and March 2009 and the Respondent provided additional prescriptions.

vi. By July 2009 the Respondent wrote prescriptions for Fentanyl 200mcg every three days, Methadone 120mg/24, Oxycontin 400mg/24 and Oxycodone 210mg/24.

vii. The medical records identified that MD attended a pain management group. The Respondent documented that MD was compliant with urine toxicology screens and that the urine screens were satisfactory without substance abuse.

viii. The urine toxicology screens from January 2008 through August 2009 identified that MD tested positive and/or had traces of the following:
   1. Cocaine on ten different occasions from February 2008 through July 2009.
   2. THC on April 30, 2008.
   3. Alcohol on three different occasions from February 2009 through August 2009.

ix. The urine toxicology screens from January 2008 through August 2009 identified that MD tested negative for the following prescriptions prescribed by the Respondent:
   1. Methadone on fifthteen occasions from March 2008 through June 2009.
   2. Fentanyl on nine different occasions from January 2008 through April 2009.

c. The pharmacy records from January 2008 through August 2009 identified the following:

i. The address on record identified that MD lived in Durham, CT.

ii. MD traveled to different towns to different pharmacy chains on the same day and/or same week in order to fill prescriptions written by the Respondent (Cromwell, Berlin, Middletown, Wethersfield, Rocky Hill, Greenwich, Durham and Northford).

iii. MD alternated the payment of his prescriptions with Medicare, Medicaid, cash and other insurances.

iv. On April 10, 2008, the Respondent wrote a prescription for Methadone 10mg (100) for days with a note that identified, "For chronic pain".

v. On September 2, 2008, the Respondent wrote a prescription for Oxycodone 30mg (100) for 12 days with a note that identified, "Compression fracture of spine/bulging disc, for breakthrough pain".

vi. On January 19, 2009, the Respondent wrote a prescription for Oxycontin 80mg (50) for 7 days with a note that identified, "To replace stolen meds, increase due to compression fracture of spine, bulging disc and post op knee surgery".
vii. The medical record lacked documentation for the following prescription written by the Respondent and filled by MD:
    1. August 20, 2008 = Methadone 10mg (100) for 8 days.
viii. The medical records lacked documentation for the following prescriptions written by the Respondent that were presented to the Walgreens pharmacy and not filled by MD:
    1. February 6, 2008 = Fentanyl 100mcg (20 patches) for 30 days.
    2. April 10, 2008 = Oxycodone 20mg ER (80) for 16 days.
    3. April 11, 2008 = Oxycontin 80mg (100) for 12 days and
        i. Oxycontin 20mg (80) for 16 days.
    4. September 2, 2008 = Oxycodone 30mg (100) for 12 days.
    5. November 12, 2008 = Fentanyl 100mcg (20 patches) for 30 days.
ix. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by MD:
    1. January 7, 2009 = Methadone 10mg 4 tablets TID (100).
    2. January 14, 2009 = Methadone 10mg 4 tablets TID (50).
    3. March 4, 2009 = Oxycontin 20mg 2 tablets BID (40) and
        i. Oxycontin 80mg 2 tablets BID (20).
    4. March 25, 2009 = Roxycodone 15mg 2 tablets every three hours (100).

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

d. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that MD had a diagnosis of chronic cervical shoulder girdle myofascial pain and left thoracic outlet syndrome, traumatic arthritis to left hip and knee, carpal tunnel syndrome (2003), compression fracture to spine (2004), degenerative disc disease with lumbar disc herniation, hepatitis C, and severe recurrent major depression.
ii. The Respondent identified that since 2002 he has been prescribing Fentanyl patches and in 2004 he added Oxycodone at 1040mg per day to treat MD's symptoms.
    1. The Respondent identified that since the Fentanyl patches did not adhere well due to weather, MD required additional analgesia that resulted in Methadone being added in 2007.
    2. The Respondent identified that there were no further increases in 2008.
iii. The Respondent identified that he had an understanding with MD that MD would use less medications at times if he needed to use less.
    1. The Respondent identified that MD would decide which medications he would use and which ones would go unfilled.
    2. The Respondent further identified that under these circumstances, patients would return unused prescriptions and the Respondent noted that there was no abuse demonstrated by MD.

iv. The Respondent identified that he did address the illicit drug use as evidenced in the urine toxicology screens and recommended that MD refrain from the use of illicit drugs.
    1. Given in the low levels of illicit drugs found in the urine toxicology screens, the Respondent identified that based on his medical opinion MD did not meet the criteria for substance abuse.

e. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient MD in the following areas:

Professional Ethics:

1. Writing prescriptions based on the notes of an unlicensed practitioner.
    a. The Respondent co-signed the clinical notes of other unlicensed practitioners and prescribed medications based upon these visits without completing his own documented evaluation on numerous occasions.
    b. The Consultant opined that this is a moderate deviation from the standard of care and identified that in her review of the literature, that this may indicate professional misconduct.

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, and the care appears to be driven by patient request.
        i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.
    c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.

b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to MD.
    i. The Consultant identified that instead, the Respondent prescribed large doses of schedule II controlled substances in a two-month period in 2009 without evidence that the Respondent saw MD in an office visit.
    ii. The Consultant opined that it is well below the standard to prescribed controlled substances without assessing and evaluating the patient.
c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of MD's increasing dependence on opioid medication.

Evaluation:

1. Failure to address tolerance and potential lethal toxicity with the patient that is prescribed combinations of excessively high doses of opioid medications.
    a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
        i. The medical record identified that the patient was seen in a pain management group and that the clinician would discuss the patient's psychological and social stressors with the Respondent.
        ii. The medical record lacked documentation that the Respondent was made aware of the patient's psychological and social stressors.
        iii. The medical record identified that many of the prescriptions were written for vague reasons and without the benefit of the Respondent seeing the patient according to the Consultant.
            1. In July 2009 the Consultant identified that the Respondent prescribed 200 tablets of Methadone 10mg, 120 tablets of Oxycodone 20mg, 200 tablets of Oxycodone 30mg, 120 tablets of Oxycontin 80mg, 120 tablets of Oxycontin 40mg, 120 tablets of Oxycodone 30mg and 120 tablets of Oxycontin 60mg to MD without an office visit with the Respondent since April 29, 2009.
    b. The Consultant opined that it is below the community standard to prescribe excessively high doses of controlled substances and in combination without evaluating the patient.
    c. The Consultant further opined that it is substandard care to prescribe schedule II controlled substances for unclear indications.
        i. The Consultant further identified that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.

ii. The Consultant identified that in the literature she reviewed, the use of opioid medications was identified as mostly for acute monophasic pain and not for non-cancer or non-progressive chronic pain syndromes.

Prescribing Practices:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient with objective evidence of the patient engaging in criminal and dangerous behaviors.
    a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior.
        i. The Consultant identified that the medical record identified that MD's admission to using "old morphine" obtained from a friend, his urine toxicology screens testing positive for illicit drugs (cocaine and marijuana) and medications not prescribed by the Respondent along with testing negative for medications prescribed by the Respondent while on probation, all suggest possible misuse or diversion by the patient.
            1. The Consultant further identified that the medical record lacked documentation that the Respondent addressed the patient's behaviors or altered treatment based on the patient's behaviors.
        ii. The Consultant opined that it is below the standard of care to prescribe controlled substances to a patient that is demonstrating misuse or diversion of their medications.
    b. The Consultant identified that it is the standard of care to ensure that the patient is not misusing the medication or engaging in further criminal conduct.
        i. The consultant identified that the pharmacy records identified that MD behaviors of utilizing multiple pharmacy chains in different towns and alternating paying for the prescriptions written by the Respondent with different insurances and cash should have alerted the Respondent to possible misuse and diversion of medications prescribed.
    c. The Consultant opined that the Respondent's prescribing of schedule II medications to a clearly dependent patient and failing to alter the treatment plan when objective evidence indicating that MD was engaging in criminal and dangerous behaviors, is a severe disservice to this patient and a severe deviation from the standard of care.

Patient F (DTW) (38 y/o)

I. A historical outline was developed and copies of Patient's F (DTW) medical records, primary care physician (PCP) office records and pharmacy records were received from February 25, 2009 thru June 16, 2010 (Exhibit I).

a. The historical outline identified the following:

i. From January 2008 through June 2009 the Respondent cosigned medication review notes written by another practitioner (unlicensed practitioner) for 5 out of 23 visits.

ii. The Respondent failed to address DTW's behaviors of requesting Suboxone prescriptions early and without office visits.
    1. In addition he failed to address her urine toxicology screens that tested negative for Suboxone.
iii. The Respondent failed to address urine toxicology screens that tested positive for medications not prescribed by him and for illicit drugs (Cocaine).
iv. DCD reported that on October 1, 2008 and October 2, 2008, DTW presented identical prescriptions at two different pharmacies. All four prescriptions were written on the Respondent's taper proof prescription pad.
v. DTW utilized multiple pharmacy chains in numerous towns to fill prescriptions written by the Respondent.

b. The medical records (Respondent's office records) from January 2008 through July 2009 identified the following:

i. The medical record identified that DTW had diagnoses that included Migraines, post status pseudomeningocele (2002), psoriatic arthritis, post status herniated disc at the L4-L5 level, and chronic pain disorder.
    1. In September 2006, a MRI identified small left paracentral disc herniation at the L4-L5 level.
    2. In July 2002, a psychiatric evaluation identified that DTW had a history of seeking Valium without a valid medical diagnosis.
ii. In January 2008 the Respondent prescribed Suboxone 20mg PRN/24, and a one-time prescription for Xanax 1mg PRN/24 and Tenex 2mg/24.
    1. In February 2008, DTW identified that she was taking cough medicine when the Respondent confronted her on the unsatisfactory urine toxicology screen.
iii. By September 2008, the Respondent prescribed Suboxone 24mg/24, Oxycontin 300mg/24 and Percocet 80mg PRN/24.
iv. On October 1, 2008 only one prescription for Oxycontin 40mg and one prescription for Oxycontin 80mg was written by the Respondent and documented in the medical record.
    1. During the October 15, 2008 office visit, DTW denied any knowledge of how she was able to present duplicate prescriptions of the Oxycontin 40mg and Oxycontin 80mg to two different pharmacies when the Respondent confronted her.
        a. She further identified that she was obtaining Benzodiazepines from her PCP.
v. By December 2008, the Respondent prescribed Flector Patch 4 patches/24, Soma 350mg/24, Suboxone 24mg/24, Oxycontin 180mg/24 and Percocet 80mg PRN/24.
vi. In November 2008 DTW identified that she was prescribed Valium and cough medicine from her PCP, when confronted on the urine toxicology screens testing positive for Benzodiazepines, Hydrocodone, and Hydromorphone.
vii. The medical record identified that the Respondent documented that the urine toxicology screens were satisfactory the rest of the time.
viii. In April 2009 the Respondent prescribed Opana 80mg/24, Suboxone 24mg/24, Oxycontin 180mg/24 and Percocet 80mg PRN/24 and in July 2009, Soma 350mg/24 was added.
ix. The urine toxicology screens from January 2008 through July 2009 identified the following:
    1. DTW had traces and/or tested positive for Cocaine on February 21, 2008, May 7, 2008, June 25, 2008, and October 22, 2008.

2. DTW tested negative for prescribed Suboxone on six different occasions from March 2008 through March 2009.
3. DTW tested positive for medications not prescribed by the Respondent such as Benzodiazepines, Hydrocodone and/or Hydromorphone on 30 different occasions from March 2008 through July 2009.
4. DTW tested positive for Morphine on June 3, 2009 and positive for Methadone on June 24, 2009, neither medication was prescribed by the Respondent.

c. The pharmacy records from January 2008 through August 2009 identified the following:

i. The addresses on record identified that DTW lived in Bristol and New Britain, CT.
ii. No prescribers or prescriptions for Valium (or any other Benzodiazepine), Morphine, Methadone and prescription strength cough medication were identified prior to July 2009.
    1. The only prescription for Hydromet Syrup written by DTW's PCP was on July 9, 2009
iii. On October 1, 2008, DTW filled a prescription for Oxycontin 80mg (30 pills for 30 days) and Oxycontin 40mg (30 pills for 30 days) at the CVS in Southington.
iv. The pharmacy search further identified that on October 2, 2008, DTW filled a prescription for Oxycontin 80mg (30 pills for 30 days) and Oxycontin 40mg (30 pills for 30 days) at the Price Chopper in Southington.
    1. In addition, DTW presented a prescription for Oxycontin 40mg (30 pills for 30 days) that was not filled at the Walgreens Pharmacy in Southington on October 1, 2008.
v. DTW traveled to different pharmacy chains in different towns on the same day and/or same week in order to fill prescriptions written by the Respondent (Bristol, Plainville, Southington, and Kensington).
vi. In addition to utilizing multiple pharmacy chains, DTW alternated the payment of her prescriptions between cash and Medicaid.
vii. The medical record lacked documentation for the following prescriptions that were written by the Respondent and filled by DTW:
    1. July 2, 2008 = Oxycontin 40mg (30) 15 days.
viii. The medical record lacked documentation of the following prescriptions that were presented to the various Walgreens Pharmacies and not filled by DTW:
    1. July 28, 2008 = Oxycontin 40mg (30) 30 days and
        i. Percocet 10mg (85) 10 days.
    2. July 30, 2008 = Oxycontin 40mg (30) 15 days and
        i. Percocet 10mg (85) 10 days.
    3. August 20, 2008 = Percocet 10mg (120) 15 days.
    4. August 24, 2008 = Percocet 10mg (120) 15 days.
    5. October 23, 2008 = At the CVS Pharmacy in Bristol = Percocet 10mg (120).
    6. October 29, 2008 = Oxycontin 60mg (30).
    7. November 30, 2008 = Oxycontin 60mg (30) 30 days.
    8. December 24, 2008 = Oxycontin 60mg (30) 30 days.
ix. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by DTW:
    1. March 13, 2008 = Suboxone 8mg/2mg 3 tablets QD (60).
    2. April 10, 2008 = Suboxone 8mg/2mg 3 tablets QD (60).

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

x. The pharmacy record identified that on April 24, 2008, DTW filled a prescription that the Respondent wrote for Endocet (Percocet) 10/325mg (60) for 15 days with a note that identified, "May use with Suboxone for flare up of Psoriatic Arthritis Pain."
    1. DTW filled a prescription for Oxycontin 40mg (15) for 15 days on the same day and time.
    2. This same pattern continued and additional opioid medications were added until the end of the pharmacy search on July 2009.

xi. The pharmacy records identified that on June 4, 2008, in addition to the Endocet prescription, DTW filled a prescription that the Respondent wrote for Oxycontin 40mg (15) for 15 days with a note that identified, "Diagnosis Psoriatic Rheumatoid Arthritis".

xii. The pharmacy records identified that DTW filled a prescription on November 5, 2008 written by the Respondent for Percocet 10/325mg (120) for 15 days with a note that identified, "May use with Suboxone, flare up psoriatic arthritis pain, kidney stone."
    1. This same note is utilized on Percocet prescriptions written from November 5, 2008 through July 2009.

xiii. The pharmacy records identified that DTW filled a prescription on November 9, 2008 written by the Respondent for Oxycontin 60mg (30) for 30 days with a note that identified, "Use with 40mg and 80mg, Diagnosis Psoriatic Rheumatoid Arthritis".
    1. This same note is utilized on Oxycontin 60mg prescriptions from November 2008 through February 2009.

xiv. The pharmacy records identified that DTW filled a prescription on November 12, 2008 written by the Respondent for Suboxone 8.64/ 2.44mg (60) for 30 days with a note that indentified, "Patient with chronic pain, dissolve under tongue."
    1. The same note is utilized on Suboxone prescriptions written from November 2008 through June 2009.

xv. The pharmacy records identified that DTW was filling prescriptions of Atarax and Enbrel prescribed by other practitioners.

d. The office records of DTW's PCP identified the following:

i. The PCP identified that DTW was seen twice after July 2008.
    1. The first occasion was to place a PPD before DTW started the immune modulating drug, Enbrel.
    2. The second occasion was when DTW presented with knee pain that he felt was due to psoriatic arthritis and referred her to a rheumatologist.

ii. The PCP's office records lacked documentation for any scheduled II controlled substances prescribed to DTW.

e. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that DTW had diagnoses of psoriatic arthritis, migraine headache disorder, T11-T12 laminectomy and removal of pseudomenigocele (2002),

degenerative disc disease with L4 –L5 disc herniation, opioid dependence, anxiety disorder NOS, r/o PTSD (rule out post traumatic stress disorder) and multiple chronic pain etiologies.

ii. The Respondent identified that due to its molecular fingerprint, Suboxone is a very effective analgesic and there are certain advantages to use it adjunctively with other opioid analgesics.
    1. The Respondent identified that DTW reported that Suboxone would exacerbate her migraine symptoms and that DTW understood to put the Suboxone on hold during those episodes.
        a. The Respondent further identified that DTW reported relief of her symptoms with the Maxalt and Topomax regime.

iii. The Respondent identified that DTW reported that her PCP had a record of prescribing Hycodan and Tussionex (cough medications that contain Hydrocodone).
    1. He further identified that the low levels identified in the positive urine toxicology screens lead him to believe that DTW was using them appropriately.

iv. The Respondent identified that DTW reported that her OB/GYN and PCP prescribed benzodiazepines to treat her back spasms and anxiety.
    1. He further identified that the low levels identified in the positive urine toxicology screens lead him to believe that DTW did not represent substance abuse or illicit drug use.
    2. The Respondent identified that the trace levels of morphine are usually dietary in origin and that DTW acknowledged that she obtained Methadone when her analgesia regime was not sufficient.
        a. The trace levels of Cocaine suggest recreational use and the Respondent identified he advised DTW to abstain.

v. The Respondent identified that he did not know how consulting with DTW's APRN would be germane to his decision as the physician managing the pain regime to add Oxycontin 60mg on September 17, 2008.

vi. The Respondent identified that prescribing Flector (Voltaren) patches had advantages because DTW did not have a history of hypertension, her history of migraines carried no particular risk for the use of NSAIDs and that the blood levels of the Flector patch are less than 1% of orally administered medications.

vii. The Respondent identified that his prescribing pattern required that DTW submit to urine testing a minimum of three times per month.
    1. The Respondent identified that he was alarmed by the set of two prescriptions filled on October 1 and 2, 2008.
        a. He identified that he had a record of the October 1, 2008 prescriptions, as that was the date DTW submitted her urine sample.
            i. In addition, he identified that he utilized computer generated security paper printed prescriptions to prevent copies and is not sure how to prevent this from occurring in the future.
        b. He further identified that DTW denied any knowledge of the different dates and seemed to be appropriately upset.
            i. He identified that he could not determine if the respective pharmacies could document who signed for the medications, with what identification and using what payment source.

ii. Given the light of uncertainty, he did not feel discharging DTW was warranted.

viii. He further identified that given 4 episodes of trace Cocaine, 1 episode of dietary morphine and 1 episode of methadone in 20 months of treatment, did not warrant discharge from treatment.

f. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient DTW in the following areas:

Professional Ethics:

1. Writing prescriptions based on the notes of an unlicensed practitioner.
    a. The Respondent co-signed the clinical notes of other unlicensed practitioners and prescribed medications based upon these visits without completing his own documented evaluation on numerous occasions.
    b. The Consultant opined that this is a moderate deviation from the standard of care and identified that in her review of the literature, that this may indicate professional misconduct.

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, and the care appears to be driven by patient request.
        i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.
    c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.

b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to DTW.
    i. The Consultant identified that although the Respondent had obtained medical records and diagnostic imaging from other practitioners, these medical records did not support the subsequent medication seeking behavior of DTW when she began attending the Respondent's clinic or the large amounts of pain medication that the Respondent prescribed.
        1. During the initial intake, DTW identified that she had been taking 70mg to 120mg of Percocet per day at $100 to $150 per day that she crushed and snorted.
        2. DTW further identified that she bought medications from people who obtained their medications from pain clinics in Bristol and Meriden and that "chasing pills is a full time job."
    ii. The Consultant identified that the pharmacy and medical records indicated that DTW received multiple prescriptions for Oxycontin, Oxycodone, and Suboxone without any clear past or present indication that she needed multiple prescriptions of opioid medications along with Suboxone.
        1. She further identified that patients who continue to take opioids should be warned strongly of the dangers of doing so with Suboxone.

c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of DTW's increasing dependence on opioid medication.

Evaluation:

1. Failure to address tolerance and potential lethal toxicity with the patient that is prescribed combinations of excessively high doses of opioid medications.
    a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
        i. The Respondent's prescription log identified that on January 31, 2008 he prescribed Suboxone 24/6mg per day along with Tenex 1mg BID and Xanax 0.5mg BID.
            1. By June of 2009, the Respondent's prescription log identified that he prescribed Opana ER (Oxymorphone) 40mg 2 tablets/24 (60 tablets total for the month), Oxycontin 60mg every day (30 tablets for the month), Oxycontin 40mg 1 to 2 tablets/24 (60 tablets for the month), Oxycontin 80mg every day (30 tablets for the month), Percocet 10/325mg 2 tablets 4 times a day (240 tablets for the month which is the equivalent of 300mg of Oxycodone and the equivalent dose of 150mg Morphine per day).

b. The Consultant identified that these prescriptions are for exceedingly high doses of medications and prescribed in combination.
    i. The Consultant identified that it is not the standard of care to prescribe opiates with Suboxone, as drug interactions are a risk as well as lowering of effectiveness of both drugs.
        1. In addition, the Consultant identified that serious withdrawal symptoms can emerge as well as increased risk of opiate abuse.
    ii. The Consultant opined that this practice is below the community standard of care.
c. The Consultant further identified that there is no clear indication and appears to be no clinical rationale for the prescription of Suboxone in combination with opioid medications.
    i. The Consultant opined that these prescriptions reflect a substandard level of care and that the Respondent's practice is a severe deviation from the community standard.

Prescribing Practices:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient and in combination with Suboxone along objective evidence of the patient engaging in criminal and dangerous behaviors.
    a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior.
        i. The medical records identified that DTW had urine toxicology screens that were positive for street drugs of abuse (Cocaine and Methadone) and negative for the prescribed Suboxone, filled identical prescriptions at two different pharmacies and used multiple pharmacy chains in different towns.
            1. According to the Consultant, these behaviors should have alerted the Respondent for possible misuse and abuse of the prescribed medications.
        ii. The Consultant identified that the Respondent does not address these behaviors in a timely or effective manner and continues to prescribe a variety of medications that are known to cause serious substance dependence.
    b. The Consultant opined that it is below the community standard to prescribe excessively high doses of controlled substances and in combination to patient with a known substance abuse history for unclear indications.
        i. The Consultant further identified that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.
        ii. The Consultant identified that in the literature she reviewed, the use of opioid medications was identified as mostly for acute monophasic pain and not for non-cancer or non-progressive chronic pain syndromes.

c. The Consultant opined that the Respondent's prescribing of schedule II medications to a clearly dependent patient and failing to alter the treatment plan when objective evidence indicating that DTW was engaging in criminal and dangerous behaviors, is a severe disservice to this patient and a severe deviation from the standard of care.

Patient G (LW) (48 y/o)

J. A historical outline was developed and copies of Patient's G (LW) medical records and pharmacy records were received from February 25, 2009 thru June 16, 2010 (Exhibit J).

a. The historical outline identified the following:

i. From July 2008 through August 2009, LW filled her prescriptions written by the Respondent at Walgreens in Berlin, CT and paid with insurance (HUMCT, ALPHA and/or Medicaid).

1. In April 2009, LW paid $13,487.17 in cash for prescriptions written by the Respondent.
2. In May 2009, LW paid an additional $13,487.17 for a total of $26,974.34 paid in cash for prescriptions written by the Respondent.

ii. All other prescriptions written by other practitioners were filled at Rite Aid in Middletown, CT.

b. The medical records (Respondent's office records) from January 2008 through May 2009 identified the following:

i. The medical record identified that LW had diagnoses that included schizoaffective disorder and pain disorder.

1. In June 2008 a MRI identified condromalacia of femoral articular cartilage with a cyst on the right pelvis.
2. In October 2007 a MRI identified C3-C5 severe degree of central spinal canal stenosis, moderate degree at C6-C7.
3. In April of 2004 LW was hospitalized for acute psychosis from poly narcotic withdrawal. A bone scan identified no significant findings in lower limber spine or hips.
4. In December 2003 LW was treated for burns on her leg when she fell asleep holding a cigarette.

ii. In January 2008 the Respondent prescribed Duragesic Patch 175mcg every three days, Oxycontin 3360mg/24 and Oxycodone 300mg PRN/24.

iii. The medical record identified that the Respondent wrote new prescriptions prior to the old prescriptions expiring.

a. For example on July 24, 2008 prescriptions for Oxycontin 80mg for 720 tablets and Oxycontin 40mg for 660 tablets were written and the same prescriptions were written again on August 4, 2008 **(11 days later)**.
b. On June 30, 2008 a prescription for Oxycontin 60mg for 90 tablets was written and the same prescription was written again on July 16, 2008 **(16 days later)** and August 4, 2008 **(19 days later).**

iv. In July 2008 the Respondent added Dilaudid 40mg PRN/24.

v. In November 2008 the Respondent prescribed Fentora 800mcg PRN/24, Oxycontin 3750mg/24 and Oxycodone 300mg PRN/24.

vi. From March 2009 through May 2009, the Respondent prescribed Fentora 800mcg PRN/24, Actiq 6400mcg PRN/24, Oxycontin 2700mg/24 and Oxycodone 300mg PRN/24.

1. Of note, the medical records identified that there were no office visits conducted in 2009 by the Respondent, LW only attended the pain management group run by another practitioner.

vii. LW attended a pain management group that was conducted by another practitioner in the Respondent's office.

viii. On February 25, 2009, the Respondent hand delivered the requested medical records to the Department. At that time he informed the Department that he did not conduct urine toxicology screens on LW because "I know she is taking all her medications".

c. The pharmacy records from January 2008 through August 2009 identified the following:

i. The address on record identified that LW lived in Cromwell, CT and had the same address as Patient H (KOC).

ii. LW went to the Rite Aid pharmacy in Middletown to fill her prescriptions from other practitioners.

iii. Her prescriptions written by the Respondent were filled at Walgreens in Berlin.

iv. LW also made numerous visits to each pharmacy each week to fill her prescriptions written by the Respondent and her other practitioners.

v. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by LW:
   1. May 30, 2008 = Oxycontin 60mg (90) for 30 days.
   2. August 27, 2008 = Oxycontin 80mg (720) for 30 days.

vi. The medical record lacked documentation for the following prescriptions written by the Respondent that were presented to the Walgreens pharmacy but not filled by LW:
   1. January 17, 2008 = Oxycontin 30mg (120) and
      i. Oxycontin 30mg (120).
   2. January 18, 2008 = Duragesic Patch 100mcg (10 patches).
   3. February 1, 2008 = Oxycontin 20mg (90) for 30 days and
      i. Oxycontin 40mg (660) for 30 days.
   4. April 2, 2008 = Oxycontin 20mg (90) for 30 days.
   5. April 8, 2008 = Oxycontin 10mg (90) for 30 days.
   6. April 14, 2008 = Oxycontin 40mg (660) for 30 days.
   7. April 20, 2008 = Oxycodone 40mg ER (660) for 30 days.
   8. May 13, 2008 = Oxycontin 20mg (90) for 30 days and
      i. Oxycontin 20mg (90) for 30 days.
   9. May 23, 2008 = Oxycodone 20mg ER (90) for 30 days and
      i. Oxycontin 60mg (90) for 30 days.
   10. May 30, 2008 = Oxycontin 60mg (90) for 30 days.
   11. June 9, 2008 = Oxycontin 40mg (660) for 30 days and
      i. Oxycontin 80mg (720) for 30 days.
   12. June 30, 2008 = Oxycontin 40mg (660) for 30 days and
      i. Oxycontin 40mg (660) for 30 days and
      ii. Oxycontin 60mg (90) for 30 days and
      iii. Oxycontin 60mg (90) for 30 days and
      iv. Oxycodone 30mg (120) for 10 days.
   13. July 1, 2008 = Oxycontin 40mg (660) for 30 days and
      i. Oxycontin 40mg (660) for 30 days and
      ii. Oxycontin 40mg (660) for 30 days.
   14. July 2, 2008 = Oxycontin 40mg (660) for 30 days.
   15. July 3, 2008 = Oxycodone 30mg (120) for 10 days.

16. July 9, 2008 = Oxycontin 60mg (90) for 30 days.
17. July 16, 2008 = Oxycontin 60mg (150) for 30 days and
    i. Oxycontin 60mg (150) for 30 days.
18. July 25, 2008 = Oxycodone 30mg (150) for 12 days and
    i. Oxycontin 60mg (150 for 30 days.
19. August 4, 2008 = Oxycontin 30mg (90) for 30 days and
    i. Oxycontin 40mg (660) for 30 days and
    ii. Oxycontin 40mg (660) for 30 days and
    iii. Oxycontin 40mg (660) for 30 days.
20. August 21, 2008 = Oxycontin 30mg (90) for 30 days.
21. August 27, 2008 = Oxycontin 80mg (720) for 30 days.
22. October 21, 2008 = Oxycontin 80mg (720) for 30 days.
23. December 1, 2008 = Oxycodone 80mg ER (720) for 30 days.
24. December 26, 2008 = Oxycontin 80mg (150) for 30 days.

vii. The pharmacy records lacked documentation that following prescriptions written by the Respondent were filled by LW:
1. February 1, 2008 = Oxycontin 80mg 2 tablets BID (120) and
    i. Oxycontin 40mg 3 tablets QHS (90).
2. February 11, 2008 = Oxycontin 20mg 3 tablets QAM (90).
3. March 17, 2008 = Oxycontin 10mg 3 tablets QAM (90).
4. May 13, 2008 = Oxycontin 60mg 3 tablets QAM (90).
5. June 30, 2008 = Oxycontin 10mg 3 tablets QAM (90).
6. July 16, 2008 = Oxycodone 30mg 2 tablets every 4 hours, PRN (150).
7. August 4, 2008 = Oxycontin 80mg 8 tablets TID (720).
8. January 26, 2009 = Roxycodone 30mg 2 tablets Q4H/PRN (150)
9. March 30, 2009 = Roxycodone 30mg 2 tablets Q4H/PRN (150)
10. May 18, 2009 = Actiq 1600mcg 1 lozenge QID/PRN (60)
    i. Actiq 1600mcg 1 lozenge QID/PRN (60)
    ii. Fentora 400mcg 1 tablet BID/PRN (28)
    iii. Oxycontin 40mg 6 tablets BID (660)

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

d. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that LW had a diagnosis of moderate to severe chronic pain since 1986, multilevel degenerative disc disease with myelopathy and spasm, status post cervical fusion, severe cervical spinal stenosis, lumbar disc disease evident from L1 though S1 (MRI 2007), bilateral shoulder bursitis, carpal tunnel syndrome, diabetes, asthma, GERD (gastro esophageal reflux disease), HTN (hypertension), hypothyroidism, dyslipidemia, vitamin D deficiency, and schizoaffective disorder.
1. Dr. Feingold and the Visiting Nurse Association (VNA) monitored and managed her intrathecal pump that was used to help manage her refractory pain.

ii. The Respondent identified that he did advise the Department that LW had no substance abuse history, was closely followed by multiple clinical providers and was not displaying evidence of impairment.
    1. He identified that the above information was the basis of his confidence that LW was safely taking her medications and was at low risk for substance abuse.

iii. The Respondent identified that because LW was involved in the pain management group, he would only see her on a minimum of every 2 to 3 months.
    1. In 2009, he identified that the office visits with LW were conducted on January 5, March 30, May 18, August 10 and 31, September 14, October 12, and November 23, 2009.
    2. He further identified that the medical record indicated that during the 9 years of treatment, he had been reducing LW's daily opioid dosage.

iv. The Respondent identified that he added Dilaudid on July 16, 2008 secondary to LW reporting increased difficulty with hip pain and an MRI that identified evidence of increased chondromalacia of the hip with a cystic lesion on the head of the femur.

v. In November 2008, LW demonstrated increased pain and spasms from her cervical disc disease and the Respondent resumed Fentora to improve the pain management.
    1. He identified that the FDA (Food and Drug Administration) is nearing approval for Fentora to treat non-cancer pain.
        a. He further identified that Actiq has similar FDA status.
    2. He identified that in the past, LW had good analgesic response to Fentanyl but he stopped the patch delivery system when she developed Cellulitis.

vi. In March 2009, he identified that he added Actiq when LW developed carpal tunnel syndrome that lead to surgery in May 2009.
    1. He further identified that at the time, there was a production problem with Oxycodone immediate release 30mg that drastically reduced it availability, which limited his options for pain management.

vii. From March to May 2009, the Respondent identified that LW did not fill her prescriptions of Actiq; she filled her prescriptions of Fentora 0.628mg, which equals 628mcg tablets.
    1. He further identified that the discrepancies between the dose written and the dose filled may have due the availability of the pharmacy.

viii. The Respondent identified that Medicare D allows insurers wide latitude in formulary changes, quantity limits, formulary exclusions, "off-label uses," etc.
    1. He identified that providers must prescribe different quantities and dosage strengths of the same medication in the same month to maintain stable daily doses.
    2. Some medications are not covered by Medicare but are covered by Medicaid.
        a. He identified that patients often have to suffer when they are in a Medicaid spend-down period because they are unable to obtain these prescriptions.

ix. The Respondent identified that there is documentation of the September 4, 2008 prescription in the medication ledger but there is no progress note because the patient came in to pick up the prescription.

x. The Respondent identified the prescriptions that were written 11, 16, or 19 days later were written according to DEA guidelines that require prescriptions be dated on the day they were written with "to filled on date xx/xx/xxxx" in the body of the prescription.

1. The Respondent identified that he mailed such prescriptions to patients a week or two ahead of time to allow for problems with mail delivery.

e. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient LW in the following areas:

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, are unclear even when typed due to brevity, and the care appears to be driven by patient request.
        i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.
        ii. The medical record lacked evidence that LW was provided information needed to give informed consent for treatment.
    c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
    b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to LW.
        i. The medical record identified that there was objective evidence of pathology that could result in chronic pain.
        ii. The Consultant identified that she was unable to find the quote utilized by the Respondent as part of his rationale for prescribing the dose of opiate medication for LW.
            1. The Respondent had quoted from the American Academy of Pain Medicine regarding that it

recognized that there is not a dose ceiling for analgesia with this class of medication and that safety and effectiveness of the regime is determined by the patient's level of function and quality of life.

a. The Consultant identified that a review of these documents did not reveal the simplistic justification the Respondent identified to explain the doses of medications he prescribed to LW.

2. The Consultant further identified that this rationale does not allow the physician to prescribe dangerously high doses of opioid medications without clear rationale based on extensive ongoing evaluation and monitoring.

a. A review of the medical record by the Consultant identified that documented evidence that the Respondent conducted ongoing evaluations and monitoring was lacking.

c. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of LW's increasing dependence on opioid medication.

Evaluation:

1. Failure to address tolerance and potential lethal toxicity with the patient that is prescribed combinations of excessively high doses of opioid medications.
   a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
   b. The Consultant identified that the usual starting dose of Oxycodone is 5-15mg every four to six hours. This dosage averages out to 90mg per day, which is in stark contrast to the 300mg per day the Respondent prescribes for LW.
      i. The Consultant further identified that in August 2008, the Respondent prescribed a daily dose of 37500mg of Oxycontin in addition to the 300mg of Oxycodone per day.
         1. The Consultant identified that the medical record lacked documentation of objective evidence to support this amount of opiate medication or that ongoing evaluation of the treatment plan was conducted.
      ii. The Consultant identified that in her review of the literature, she found that for chronic musculoskeletal pain, daily doses above 180mg of morphine or its equivalent have not been validated in clinical trials.
   c. The Consultant opined that the practice of prescribing massive doses of schedule II controlled substances without clear indications in the medical record and/or ongoing evaluations are well below the community standard of care.

Prescribing Practices:

1. Prescribing excessively high doses of opioid medication and in combination of multiple opiates and other additive medications without objective evidence to support these doses.
    a. The Consultant identified an example of the Respondent's inappropriate prescribing pattern that is indicative of the pattern he engages in throughout the record, are the prescriptions he wrote in January 2009 as identified in the following prescriptions:
        i. 1440 pills of Oxycontin 80mg for the month.
        ii. 1320 pills of Oxycontin 30mg for the month.
        iii. 300 pills of Oxycontin 60mg for the month.
        iv. 56 pills of Fentora 400mcg for the month.
    b. The Consultant identified that if the patient took these prescriptions as prescribed, she would have taken the following:
        i. 48 pills of Oxycontin 80mg per day.
        ii. 6 pills of Oxycontin 30mg per day.
        iii. 44 pills of Oxycontin 40mg per day.
        iv. 10 pills of Oxycontin 60mg per day.
            1. The Consultant identified that the number of pills at these strengths would be a total of 6380mg of just the Oxycontin per day, an equivalent of 3200mg of Morphine a day.
                a. The Consultant identified that this Morphine equivalent is 17.7 times the recommended maximum daily dose of morphine or its equivalent.
            2. The Consultant identified that even if LW took the medication every two hours around the clock, she would be taking 530mg of Oxycontin at a time.
                a. The Consultant identified that the Respondent also prescribed Roxycodone and Fentora.
            3. The Consultant further identified that LW engaged in behaviors that most practitioners would suspect misuse or abuse of her medications.
                a. In April and May 2009, LW paid $26,974.34 in cash for prescriptions that had been previously paid with insurance.
    c. The Consultant opined that the Respondent's prescribing practice is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.

Patient H (KOC) (44y/o)

K. A historical outline was developed and copies of Patient's H (KOC) medical records and pharmacy records were received from February 25, 2009 thru June 16, 2010 (Exhibit K).

a. The historical outline identified the following:

i. From January 2008 through June 2009, the Respondent co-signed medication evaluation notes written by another practitioner (unlicensed practitioner) for 8 out 24 visits.
ii. The DCD report identified that Department of Social Services (DSS) had KOC in a locked-in program for inappropriate drug use. As of March 31, 2008, KOC requested that the Walgreens in Berlin, CT be her sole pharmacy provider.
iii. The DCD report further identified that during the week of April 26, 2009, it was discovered that KOC had been filling her prescription of Xanax at the Wal-Mart Pharmacy every 15 days and paying cash since March 2008. During the same time period, KOC had been filling her prescriptions of Xanax at the Walgreens Pharmacy under her Medicaid insurance every 15 days.
iv. In addition, the pharmacy records identified from January 2009 through May 2009, KOC paid cash for Oxycontin 40mg and 60mg prescriptions written by the Respondent.
    1. In May 2009, KOC paid an estimated $3354.74 in cash for prescriptions of Xanax, Oxycontin 40mg and 60mg.

b. The medical records (Respondent's office records) from January 2008 through July 2009 identified the following:

i. KOC had a diagnosis that included Degenerative osteoarthritis in lumbosacral spine, hips, and knees with a history of addiction to pain medications.
ii. In January 2008 the Respondent prescribed Xanax 4mg PRN/24, Oxycontin 1800mg/24, Oxycodone (15mg & 30mg) 750-900mg PRN/24.
iii. By December 2008, the Respondent prescribed Xanax 4mg PRN/24, Oxycontin 1980mg/24 and Klonopin 3mg.
iv. By June 2009, the Respondent prescribed Xanax 4mg PRN/24, Klonopin 3mg/24, Methadone 40mg/24, Oxycontin 1980mg/24, and Oxycodone 960mg/24.
    1. The medical record lacked documentation of an assessment for the addition of Methadone.
v. The Respondent wrote numerous prescriptions several times a week without seeing KOC in an office visit.
vi. The Respondent was writing 30-day prescriptions and renewing them every two weeks more or less.
    1. For example, on April 28, 2008 prescriptions for Oxycontin 40mg (240), Oxycontin 60mg (90) and Oxycontin 80mg (510) were written and the same prescriptions were written on May 14, 2008 **(16 days later).**
    2. For example, on July 21, 2008 prescriptions for Oxycontin 40mg (240) and Oxycontin 80mg (510) were written and the same prescriptions were written on August 6, 2008 **(16 days later).**
    3. For example, on May 14, 2009 a prescription for Klonopin 1mg TID (90) with 3 refills was written and the same prescription was written on May 19, 2009 **(6 days later).**
vii. KOC was inconsistent with her attendance in the pain management group.
viii. From March 2009 through July 2009, KOC's urine toxicology screens tested positive for alcohol four times.
    1. During this time period, Ms. O'Connor also tested positive for the following medications not prescribed by the Respondent:
        a. March 3, 2008 = Fentanyl and Morphine.
        b. April 17, 2008 = Hydrocodone.
        c. June 6, 2008 = Morphine.
        d. July 9, 2008 = Hydrocodone.

e. August 8, 2008 = Hydrocodone.
f. October 6, 2008 = Morphine.
g. November 3, 2008 = Morphine.
h. March 3, 2009 = Fentanyl and Norfentanyl.
i. April 16, 2009 = Fentanyl and Norfentanyl.
j. May 14, 2009 = Fentanyl and Norfentanyl.
k. July 6, 2009 = Buprenorphine and Fentanyl.
l. July 30, 2009 = Buprenorphine.

c. The pharmacy records from March 2008 through June 2009 identified the following:

i. The address on record identified that KOC lived in Cromwell, CT and had the same address as Patient G (LW).
ii. KOC filled her prescriptions of Xanax and Klonopin that were written by the Respondent at Walgreens under her Medicaid insurance and at times, paying cash.
iii. During this same time period, KOC filled her prescriptions of Xanax written by the Respondent at the Wal-Mart in Cromwell and New Haven **(not her contracted pharmacy)** under her Medicaid insurance and at times, paying cash.
    1. In addition, KOC filled her prescriptions of Klonopin written by the Respondent at Marc Glassman Pharmacy in Glastonbury **(not her contracted pharmacy)** and paying cash.
iv. On July 6, 2009, the Respondent wrote a prescription for Methadone 10mg QID (120) with a note that identified, "Patient with chronic pain."
    1. An identical prescription for Methadone was also written on July 30, 2009 with the same notation.
v. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by KOC:
    1. March 21, 2008 = Alprazolam 1mg (60) for 15 days written on March 15, 2008.
    2. April 16, 2008 = Alprazolam 1mg (60) for 15 days written on March 15, 2008.
    3. June 2, 2008 = Oxycontin 80mg (510) for 30 days and Oxycontin 40mg (240) for 30 days written on June 2, 2008.
    4. June 18, 2008 = Alprazolam 1mg (60) for 15 days written on June 18, 2008.
    5. June 30, 2008 = Alprazolam 1mg (60) for 15 days written on June 18, 2008.
    6. December 17, 2008 = Clonazepam 1mg (90) for 30 days that was written on December 16, 2008.
    7. February 11, 2009 = Alprazolam 1mg (60) for 15 days written on February 10, 2009.
    8. March 2, 2009 = Alprazolam 1mg (60) at Walgreens.
    9. March 7, 2009 = Alprazolam 1mg (60) at Walgreens.
    10. March 18, 2009 = Alprazolam 1mg (60) written on February 19, 2009 (The refills on the February 19, 2009 prescriptions had expired all refills on March 6, 2009 at the Wal-Mart Pharmacy (not her contracted pharmacy).
    11. May 5, 2009 = Clonazepam 1mg (90) for 30 days.
        a. The last prescription was written on January 13, 2009 and KOC had filled all 4 prescriptions by April 8, 2009.
vi. The medical record lacked documentation for the following prescriptions written by the Respondent that were presented to the Walgreens pharmacy but not filled by KOC:
    1. January 2, 2008 = Oxycontin 20mg (120) for 30 days and
        i. Oxycontin 20mg (120) for 30 days and

ii. Oxycontin 10mg (120) for 30 days.

2. January 8, 2008 = Oxycontin 80mg (240) for 14 days.
3. January 14, 2008 = Oxycontin 40mg (240) for 30 days and
   i. Oxycodone 15mg (120) for 20 days.
4. January 28, 2008 = Oxycontin 80mg (120) for 30 days and
   i. Oxycodone 80mg ER (120) for 7 days.
5. February 11, 2008 = Oxycontin 80mg (510) for 30 days.
6. March 3, 2008 = Oxycontin 80mg (510) for 30 days.
7. March 27, 2008 = Oxycontin 40mg (240) for 30 days.
8. April 19, 2008 = Oxycontin 80mg (200) for 12 days.
9. May 5, 2008 = Oxycodone 80mg ER (510) for 30 days.
10. May 25, 2008 = Alprazolam 1mg (60).
11. June 16, 2008 = Oxycodone 80mg ER (510) for 30 days and
    i. Oxycontin 40mg (240) for 30 days.
12. June 30, 2008 = Oxycontin 80mg (510) for 30 days and
    i. Oxycontin 40mg (240) for 30 days and
    ii. Oxycontin 80mg (510) for 30 days and
    iii. Oxycontin 40mg (24) for 30 days.
13. July 9, 2008 = Oxycontin 60mg (90) for 30 days and
    i. Oxycontin 30mg (90) for 30 days.

vii. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by KOC:

1. January 1, 2008 = Oxycontin 20mg 2 tablets BID (120).
2. May 28, 2008 = Only 1 of the 3 scripts of Xanax 1mg QID PRN (60) was identified as being filled in the pharmacy search).
3. June 5, 2008 = Only 2 of the 4 prescriptions of Klonopin 1mg TID (90) could be identified as filled in the pharmacy search.
4. August 6, 2008 = Oxycontin 60mg 5 tablets QD (75).
5. October 10, 2008 = Xanax 1mg QID, PRN (60) 2 refills.
6. December 22, 2008 = Oxycontin 80mg 6 tablets BID, 5 tablets QHS (510).
7. May 14, 2009 = Klonopin 1mg TID (90) 3 refills.
8. May 19, 2009 = Klonopin 1mg TID (90) 3 refills.
   a. Only 2 of the 4 prescriptions were identified as being filled at Marc Glassman Pharmacy in Glastonbury **(not her contracted pharmacy).**
9. June 11, 2009 = Oxycontin 40mg 4 tablets BID (240) and
   a. Oxycontin 60mg 5 tablets QD (150).
10. June 17, 2009 = Oxycodone 30mg 5 tablets QID (280).

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

d. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that KOC had a diagnosis of major recurrent depression, panic disorder without agoraphobia, alcohol dependence, partial remission, chronic

pain resulting from degenerative disc disease with a history of three herniated lumbar discs, cervical spinal stenosis, diabetic neuropathy, degenerative arthritis of hips and knees, obesity, adult onset diabetes, cardiomyopathy (diagnosed in 2009), hypothyroidism, dyslipidemia and vitamin D deficiency.

ii. The Respondent identified that KOC was referred to him in 2000 for the management of her chronic pain and psychiatric difficulties in light of her history of alcohol dependence.
    1. At the initial evaluation, KOC had been sober since 1996 and KOC continued to remain active in individual therapy, pain management groups and women's relapse group that resulted in 13 years sobriety until March of 2009.
    2. The Respondent identified that his March 19, 2009 note documented steps that KOC took to shore up her sobriety with subsequent progress notes documenting her struggles.
        a. From March through July 2009, KOC had been utilizing alcohol to help her sleep.

iii. The Respondent identified that he did address the medications taken that were not prescribed by him with KOC in his August 27, 2009 note.
    1. He identified that KOC had increased difficulty with pain and mobility from her hips, knees and spine with falls reported as noted in the chart.
    2. He identified that KOC supplemented her regimen because she was experiencing increased arthralgias.
        a. He further identified that the literature frequently notes that patients suffering from chronic pain who take additional medications invariably are trying to manage their pain or to minimize symptoms from "overusing" medications due to increased suffering.
            i. The literature further identifies according to the Respondent that these patients are not looking for a "high" or "euphoria."
            ii. According to the Respondent, the literature identified that the clinical response is to pursue the appropriate work up and assessment and to stress the importance of the patient to let the physician decided what medication regimen should be implemented.
    3. Based on the literature and KOC's clinical picture, punitive dose reductions or discharge from treatment were not a consideration.

iv. The Respondent identified that he prescribed 1480mg of Oxycodone daily since 2004.
    1. He identified that the Oxycodone was increased to 1600mg in 2005 and in 2006; it was increased to a daily dose of 2080mg.
        a. By July 2007, the Oxycodone was titrated down to 1680mg per day.

v. The Respondent identified that in January 2008, KOC's standing order of Oxycontin 40mg 4 tablets BID (320mg/24) suddenly required preauthorization.
    1. He identified that he prescribed a combination of Oxycontin 10mg (120) and Oxycodone 15mg (120) for a total of 3500mg used over 12 days to compensate during the 2 weeks of working through the prior authorization/appeal process.
    2. He identified that this practice of sudden denial occurred again in June 2009.
        a. He further identified that this sudden denial was the rationale for prescribing Methadone in June 2009.

vi. The Respondent identified that KOC had been prescribed Klonopin 1mg TID since 2000 because of its significant muscle-relaxant properties and Alprazolam 1mg TID to treat symptoms of her panic disorder since 2000.
    1. He identified that KOC reported panic symptoms despite the Klonopin and increasing the dosage caused more sedation without improving efficacy, which is why he added Alprazolam.

vii. The Respondent identified that regarding the benzodiazepine medications filled without documentation in the medical ledger, could be due to the possibility of occurrences of faxed/phoned prescriptions that were not properly entered into the ledger.

viii. The Respondent identified that the 30 day prescriptions written every two weeks are examples of the "to be filled on..." procedure for writing post-dated prescriptions, as previously explained.
    1. For example, he identified that the May 14th prescription indicates that it is to be filled on June 2nd, the August 6th prescription indicates that it is to be filled on August 26th.

ix. The Respondent identified that it is his understanding that he is not responsible for monitoring patient's compliance with pharmacy lock-in.
    1. He identified that he believes during spend down periods or when Medicaid is not active, patients are free to shop for medications based upon convenience and price.
    2. He further identified that prescriptions that go unfilled provides some reassurance that the patient is not involved in medication diversion practices if a "high street value" prescription goes unfilled.

e. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient KOC in the following areas:

Professional Ethics:

1. Writing prescriptions based on the notes of an unlicensed practitioner.
    a. The Respondent co-signed the clinical notes of other unlicensed practitioners and prescribed medications based upon these visits without completing his own documented evaluation on numerous occasions.
    b. The Consultant opined that this is a moderate deviation from the standard of care and identified that in her review of the literature, that this may indicate professional misconduct.

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.

b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, and the care appears to be driven by patient request.
    i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.
    ii. The medical record lacked documentation for 41 prescriptions filled by KOC.
c. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
    b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to KOC.
        i. The Consultant identified that although the Respondent had obtained medical records and diagnostic imaging from other practitioners, these medical records did not support the subsequent medication seeking behavior of KOC when she began attending the Respondent's clinic or the large amounts of pain medication that the Respondent prescribed.
            1. During the initial intake, KOC identified that she was on medical disability, was a member of Alcoholic Anonymous and was currently in treatment with another practitioner for Depression and Anxiety.
            2. The Physiatrist's evaluation conducted on May 19, 2000, identified that KOC had multiple occupational claims of disability, multiple injuries due to falls, and drug seeking behaviors for Vicodin.
                a. A recommendation was made to wean KOC off narcotics.
            3. The Consultant identified that the Respondent continued to prescribe high doses of scheduled II controlled substances despite specialist consultation and objective data that identified no myelopathy or radicular findings.
        ii. The Consultant identified that the medical records indicated that KOC received multiple prescriptions for Oxycontin and

Xanax without an office visit on multiple occasions and without clear objective evidence for the large number of tablets written per prescription.

1. The Consultant identified that on January 15, 2007, the Respondent wrote prescriptions for 17 tablets of Oxycontin 80mg per day (240 tablets total), 4 tablets of Xanax 1mg per day, with 2 refills (60 tablets total), and 8 tablets of Oxycontin 40mg per day (120 tablets total).
2. The Consultant opined that prescribing these medications in extremely high doses and with large numbers of tablets in one visit without any objective evidence of need is well below the community standard of care.

d. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of KOC's increasing dependence on opioid medication.

Evaluation

1. Failure to address tolerance and potential lethal toxicity with the patient that is prescribed combinations of excessively high doses of opioid medications and in combination with benzodiazepines.
   a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
   b. The Consultant identified that the usual starting dose of Oxycodone is 5-15mg every four to six hours. This dosage averages out to 90mg per day, which is in stark contrast to the 1680mg per day the Respondent prescribes for KOC.
      i. The Consultant further identified that on January 15, 2007, the Respondent prescribed a daily dose of 1680mg of Oxycontin in addition to the 4mg of Xanax per day.
         1. The Consultant identified that the medical record lacked documentation of objective evidence to support this amount of opiate medication or that ongoing evaluation of the treatment plan was conducted.
            a. The Consultant further identified that the urine toxicology screens were inconsistent with the Respondent's prescription log and the medical record lacked documentation that the Respondent addressed this issue with KOC.
      ii. The Consultant identified that in her review of the literature, she found that for chronic musculoskeletal pain, daily doses above 180mg of morphine or its equivalent have not been validated in clinical trials.
   c. The Consultant opined that the practice of prescribing lethal doses of schedule II controlled substances without clear indications in the

medical record and/or ongoing evaluations are well below the community standard of care.

iii. The Consultant further opined that this is a severe deviation from the standard of care and a serious disservice to the patient.

Prescribing Practices:

1. Prescribing high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient and in combination with benzodiazepine along objective evidence of the patient engaging in criminal and dangerous behaviors.
    a. The Consultant identified that is the community standard to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior.
        i. The medical records identified that KOC had urine toxicology screens were inconsistent with the Respondent's prescription log, filled her Xanax prescriptions at two different pharmacies and paid with her Medicaid insurance at her identified pharmacy and paid cash at the other pharmacy in an attempt to avoid detection. In addition, the Abilify prescriptions written by the Respondent went unfilled by KOC.
            1. According to the Consultant, these behaviors should have alerted the Respondent for possible misuse and abuse of the prescribed medications.
        ii. The Consultant identified that the Respondent failed to address these behaviors in a timely or effective manner and continued to prescribe medications that are known to cause serious substance dependence.
    b. The Consultant identified that it is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal activity.
        i. The Consultant identified that numerous prescriptions for opiate medication written by the Respondent went unfilled by KOC.
            1. The Consultant identified in the literature review she conducted, the opiate medications prescribed by the Respondent had a high street value due to its effectiveness in preventing the onset of methadone and heroin withdrawals.
        ii. The Consultant identified that the Respondent wrote several letters to KOC's insurance company advocating for the approval of extremely high doses of Scheduled II medications despite evidence of medication misuse.
    c. The Consultant opined that ignoring objective evidence of patient misuse of narcotic medications while writing letters to the insurance company reporting the opposite is clear obfuscation of the facts by the Respondent.
        i. The Consultant further opined that not only is this below the community standard of care but also enters the realm of criminal and unethical practice.

Patient I (PB) (52 y/o)

L. A historical outline was developed and copies of Patient's I (PB) medical records, pharmacy records, PCP office notes, surgeon's office notes, orthopedics' consult notes, police reports, and the autopsy report were received from February 25, 2009 thru June 21, 2010 (Exhibit L).

a. The historical outline identified the following:

i. The Respondent saw PB for all four office visits from August 2008 through November 2008.
ii. BP had several hospitalizations for medical problems and complications associated with opiate overdose.
iii. PB filled all her prescriptions at the Walgreens Pharmacy in Berlin, CT.

b. The medical records (Respondent's office records) from July 2008 through November 2008 identified the following:

i. The medical record identified that PB had diagnoses that included Major Depression, Panic Disorder, Rheumatoid Arthritis, Rhabdomyolysis, HTN, Morbid Obesity & COPD w/Asthma.
    1. On July 25, 2008 PB was admitted to the hospital for bilateral Cellulitis of her lower legs.
    2. On July 2, 2008 PB was admitted to the hospital for community-acquired pneumonia.
    3. The medical record identified that the following tests were conducted and records from other providers were obtained in 2007:
        a. A urine toxicology screen dated August 15, 2007 tested positive for Marijuana.
        b. An x-ray dated June 8, 2007 identified degenerative changes in the left ankle.
        c. On May 29, 2007 BP went to the UCONN ER for rectal bleeding and asthma.
        d. From February 19 – 24, 2007, PB was admitted to NBGH for Rhabdomyolysis, lethargy and mental status changes secondary to opioid use and a urinary tract infection (UTI).
    4. The medical record identified that additonal medical records from NBGH were obtained and identified the following:
        a. From March 15-28, 2003, PB was admitted to NBGH for mental status changes and hallucinations secondary to opioid use.
ii. In July 2008 the Respondent prescribed Fentora 3000mcg/24, Methadone 440mg/24, Vicodin 80mg/24 and Flexaril 30mg, PRN/24 to PB.
iii. By November 2008, the Respondent prescribed Dilaudid 32mg PRN/24, Flexeril 40mg PRN/24, Vicodin 120mg/24, Xanax 8mg/24, and Methadone 440mg/24 to PB.
iv. PB was seen by the Respondent in the office a total of four times prior to her untimely death of opioid toxicity on November 29, 2008.

c. The pharmacy records from July 2008 through November 2008 identified the following:

i. The address on record identified that PB lived in Berlin, CT with her husband Patient J (SB).
ii. On September 26, 2008 her PCP prescribed Dilaudid to PB.
    1. Her PCP prescribed medications to treat her HTN, asthma and sinus symptoms.
iii. The medical record lacked documentation for the following prescriptions written by the Respondent that were presented to the Walgreens pharmacy but not filled by PB:
    1. August 6, 2008 = Methadone 10mg (120) for 5 days and
        i. Fentora 600mcg (56) for 9 days.
    2. August 23, 2008 = Methadone 10mg (120) for 5 days.
    3. August 28, 2008 = Vicodin 10mg (60) and
        i. Methadone 10mg (120) and
        ii. Methadone 10mg (120) and

iii. Methadone 10mg (120) and
iv. Fentora 400mg (56).

4. September 3, 2008 = Morphine Sulfate ER 60mg (180) for 15 days and
   i. Morphine Sulfate ER 60mg (180) for 15 days.
5. September 9, 2008 = Ambien 10mg (30).
6. September 12, 2008 = Vicodin 10mg (60).
7. October 7, 2008 = Valium 10mg (180) for 30 days.
8. October 18, 2008 = Ambien 10mg (30) and
   i. Ambien 10mg (30).
9. October 24, 2008 = Xanax 2mg (60) for 15 days.
10. November 4, 2008 = Ambien 10mg (30).

iv. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by PB.

1. July 23, 2008 = Methadone 10mg (120) and
   i. Flexaril 10mg (60) with 3 refills.
2. September 3, 2008 = Flexaril 10mg (60) with 3 refills (Only 1 out of 4 Prescriptions were filled).
   i. Phenergan 50mg (120) with 3 refills (Only 3 out of 4 prescriptions were filled).
   ii. An entry for Fioricet was entered without dosage or number of tablets.
3. September 11, 2008 = MS Contin 60mg (180).
4. November 5, 2008 = Flexeril 10mg 1 tablet QID, PRN (60), 3 refills and
   i. Methadone 10mg 11 tablets QID (120) and
   ii. Methadone 10mg 11 tablets QID (120) and
   iii. Methadone 10mg 11 tablets QID (120).

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

v. The medical record lacked documentation for the following prescriptions written by the Respondent and filled by PB:

1. Valium 10mg (180):
   a. August 17, 2008.
   b. August 28, 2008, written on August 28, 2008 for 30 days.
   c. September 23, 2008, written on August 28, 2008 for 30 days.
2. Ambien CR 10mg (30) for 30 days:
   a. August 26, 2008, written on August 24, 2008.
   b. September 23, 2008, written on August 24, 2008.
3. Vicodin 10mg (60) for 7 days:
   a. August 18, 2008, written on August 18, 2008.
   b. August 24, 2008, written on August 18, 2008.
   c. August 29, 2008, written on August 29, 2008.
   d. September 3, 2008, written on August 29, 2008.
   e. September 13, 2008, written on September 12, 2008.
   f. September 19, 2008, written on September 17, 2008.

g. September 23, 2008, written on September 22, 2008.
h. September 28, 2008, written on September 22, 2008.
i. October 3, 2008, written on September 22, 2008.
j. October 6, 2008, written on October 6, 2008.
k. October 15, 2008, written on October 14, 2008.
l. October 23, 2008, written on October 14, 2008.

4. Xanax 2mg (60) for 15 days:
   a. October 15, 2008, written on September 3, 2008. The last refill from September 3, 2008 was filled on October 3, 2008.

vi. The Respondent wrote a prescription for MS Contin 60mg 3 tablets QID (180) on September 3, 2008 with a note that identified, "To replace Fentora."
vii. The Respondent wrote a prescription for Xanax 2mg 1 tablet QID (60) with 3 refills on September 3, 2008 with a note that identified, "To replace Valium."
viii. The Respondent wrote a prescription for Norco 10mg/325mg (120) on November 5, 2008 with a note that identified, "10 day supply with a maximum 12 tablets/day, 10 day supply with 2 refills = 1 month."

d. The PCP office records from January 2008 through November 2008 identified the following:

i. There were three office visits from June 2008 through October 2008.
   1. The June office visit was for the evaluation and treatment of depression, asthma and hypertension (HTN).
      a. The chronic pain evaluation and treatment were deferred to the Respondent and a list of her pain medications prescribed by the Respondent was documented.
      b. PB did not identify all medications prescribed by the Respondent nor did she provide the correct dosage prescribed by the Respondent.
   2. The September office visit was follow up appointment secondary to a hospitalization on July 2, 2008 for pneumonia and July 25, 2008 for bilateral lower leg cellulitis.
      a. Chest x-rays taken on July 2 and July 26, 2008 identified a left lower lobe opacity most likely representing a mass.
      b. Follow up examination was strongly recommended.
   3. The October office visit was a preop visit for the upcoming carpel tunnel surgery and a referral a thoracic surgeon regarding the lung mass.

e. The thoracic surgeon's office records identified the following:

i. The November 18, 2008 note identified that PB was seen for an evaluation of a left lung mass.
   1. A repeat chest x-ray dated November 25, 2008 identified no new masses or lymphadenopathy was evident.

f. The orthopedic's office records identified the following:

i. There were three office visits from April 2008 through September 2008.
ii. A nerve conduction study dated August 15, 2008 identified PB was symptomatic from her left carpal tunnel syndrome and cubital tunnel syndrome.
iii. The September 25, 2009 identified that the orthopedic surgeon would proceed with a carpal tunnel release and cubital tunnel release after medical clearance from PB's PCP.

g. The police reports identified the following:

i. The Berlin police responded to a call placed on Saturday, November 28, 2008 regarding an unconscious female.

1. The police officers identified in their report that upon arrival at 7:02AM, they met with PB's husband, Patient J (SB).
    a. SB identified that his wife was last seen alive at 10:30PM last evening watching TV.
        i. At 6:00AM, he found his wife on the floor next to the bed and spent the last hour trying to awaken her.
        ii. SB informed the police officers that he and his wife were addicted to pain medications and that he had shared his pain medications with his wife at times.
2. The police officers identified in their report that PB was found unconscious and unresponsive with no pulse or respirations. There was a large puddle/pile of vomit next to her head. Signs of rigor mortis and lividity were apparent.
    a. The police officers collected 15 prescription bottles made out to PB which included three unlabeled large pill containers with assorted prescription drugs mixed in together.
        i. One prescription container was labeled as Hydrocodone with 120 pills had been filled on November 24, 2008, but only had 33 pills remaining in the container.
        ii. A second prescription container was labeled Hydromorphone with 40 pills had been filled on November 24, 2008 and was empty.
            1. The Respondent had written both of these prescriptions.

h. The autopsy report identified the following:

i. The report dated January 22, 2009 identified that the final cause of death was accidental opiate toxicity.

i. Dr. Powers' report identified the following:

i. Dr. Powers identified that he is the Director of the State of Connecticut Controlled Substances and Toxicology Laboratory.
    1. The Department had requested his assistance in understanding the autopsy report and he agreed.
        a. After reviewing the autopsy report, he supported the findings made by the Forensic Pathologist.

j. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that PB had a diagnosis of severe, recurrent depression with psychotic features, panic disorder with agoraphobia, multilevel degenerative disc disease, spinal stenosis, post-laminectomy syndrome, migraine headaches, asthma, GERD, IBS, Fibromyalgia, osteoarthritis of hips, knees, feet, post-traumatic arthritis of foot, hypertension, fatty liver, obesity, and restless leg syndrome.
    1. Her physiatrist referred PB in 2001 for medication management of her mood, anxiety and chronic pain disorder.
    2. Upon referral, the Respondent identified that PB was opioid tolerant and prescribed Oxycontin 40mg TID, Percocet 10mg QID for pain, Klonopin 1mg QID, Soma 2 tablets QID, PRN for back spasms, Paxil 40mg, Buspar 10mg TID and Xanax 1mg TID, PRN for treatment of her mood and panic disorders.

ii. The Respondent identified based on PB losing her insurance in August 2006, he replaced the Oxycontin and Hydrocodone by titrating up the Methadone to 200mg TID.
    1. In October 2006 PB qualified for SAGA insurance and he initiated a trial of Fentanyl patch 100mcg/hour because PB reported a positive experience with this medication.
    2. In December 2006 the Respondent identified he prescribed Marinol to ease the GERD related nausea PB suffered from taking so many pills.
        a. He further identified that Marinol tests positive for cannabis.
        b. He identified that Marinol was the source of the positive cannabis result in the August 2007 urine toxicology screen.

iii. The Respondent identified that PB was hospitalized in February 2007 for Rhabdomyolysis and a urinary tract infection (UTI) and not opioid toxicity.
    1. While hospitalized, PB was prescribed Methadone 100mg TID and Zyprexia along with IV fluids and antibiotics to treat her UTI.
    2. Upon discharge, the Respondent identified he continued the Methadone 100mg TID and slowly resumed the Duragesic patch 100mcg/hour (2400mcg/day), Hydrocodone 20mg QID, and briefly Dilaudid 8mg every 4 hours after a foot injury.

iv. The Respondent identified in June 2007 he replaced the patch with Fentora 800mcg QID (3200mcg/24) due to problems with patch adhering to PB's skin.
    1. The Methadone was dosed to 160mg TID, which remained her regime until July 2008 when she was hospitalized for pneumonia.
    2. Upon his recommendation, the Respondent identified the Methadone was reduced to 240mg daily because it had recently been reported to cause central apnea.
        a. Upon her discharge from the hospital, the Respondent identified that he increased the Fentora because PB reported suffering as documented in his notes.

v. The Respondent identified that PB's insurance began to deny coverage for Fentora in September 2008 and since PB's PCP had prescribed Dilaudid, he continued the Dilaudid in October 2008.
    1. In addition to the Dilaudid, the Respondent identified that he prescribed Xanax for anxiety and to minimize the jitteriness experienced as a side effect from the Dilaudid.

vi. The Respondent identified that his notes clearly document that PB demonstrated no cognitive or behavioral impairments from her medication regime and that the news of her death was terrible news.

k. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient PB in the following areas:

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status

examination, testing, or other objective measure of the problems presented.

i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.

b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, lack sufficient detail, and the care appears to be driven by patient request through letters written and during office visits.

i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.

c. The Consultant identified that it is not the community standard to prescribe large doses of opiate medication to treat pain based solely on the patient's report of pain, letters from the patient requesting more medication, the patient's report of interventions by other physicians, and psychosocial complaints rather than objective assessments of a response to treatment.

d. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
   a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
   b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to PB.
      i. The medical record identified that as early as March 2003, PB was hospitalized with behaviors and symptoms consistent of abusing prescription narcotic medications.
         1. PB was discharged from the hospital with a diagnosis of organic mental syndrome due to opiate withdrawal.
      ii. Several other hospitalizations in 2007 at two different hospitals reflect a primary problem of opiate toxicity.
         1. The hospital records do not reflect problems with chronic pain or significant acute injury.
         2. The discharging physicians called the Respondent to discuss discharge medications as PB was identified as an unreliable historian.
            a. The discharging physician from the February 2007 admission wrote that she suspected the patient's elevated liver

function tests were due to high amounts of opiate medications, antipsychotic medications and a fatty liver.

c. The Consultant identified it is not the community standard of care to continue to prescribe high doses of opiate medication in addition to other medications that result in sedation and respiratory depression, after a patient has had hospital admissions indicating both opiate toxicity and addiction.
d. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of PB's dependence on opioid medication.

Evaluation:

1. Prescribing high doses of opiates to a patient that is misusing medications and is drug addicted.
    a. The Consultant identified that it is the standard of care to carefully prescribe scheduled II controlled substances to any patient, especially one with a history of addiction.
    b. The Consultant identified that it is the standard of care to ensure that the patient is not misusing or abusing the medication.
        i. The medical record identified that the Respondent prescribed high doses of schedule II controlled medications without objective evidence of their need and with objective evidence to the contrary, such as hospitalizations at more than one hospital with opiate toxicity listed as the primary problem.
        ii. The pharmacy records identified multiple medications that were filled without documentation in the medical record for their need or that they were prescribed.
    c. The Consultant opined that this is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II controlled medications to a clearly dependent patient is a serious disservice to the patient.
        i. The Consultant further opined that PB suffered an untimely and avoidable death due to severe addiction to opiate medications both caused by and untreated by the Respondent.

Prescribing Practices:

1. Prescribing excessively high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient and in combination with other addictive medications without addressing tolerance and potential lethal toxicity.
    a. The Consultant identified that it is the community standard to prescribe much lower doses of opiate medication and for a defined length of time.
    b. The Consultant identified that the usual starting dose of Oxycodone is 5-15mg every four to six hours.
        i. The Respondent's prescription log for October and November 2008 identified he prescribed 240 pills of Dilaudid 8mg, 1320 pills of Methadone 10mg, 180 pills of

Vicodin (Norco) 10/325mg, 60 pills of Xanax 2mg, and 60 pills of Flexeril 10mg.

ii. The Consultant identified that in her review of the literature, she found that for chronic musculoskeletal pain, daily doses above 180mg of morphine or its equivalent have not been validated in clinical trials.

c. The Consultant opined that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.

i. The Consultant further opined that the prescription of extremely high doses of opiate medication, and medications in combination with a high likelihood of toxicity prescribed by the Respondent, resulted in the untimely death of this patient.

Patient J (SB) (58 y/o)

M. A historical outline was developed and copies of Patient's J (SB) medical records, pharmacy records, medical records from skilled nursing facilities (SNF), hospital records, PCP office records, police reports and the autopsy report were received from February 25, 2009 thru June 16, 2010 (Exhibit M).

a. The historical outline identified the following:

i. From July 2008 to October 2009 the Respondent cosigned the medication evaluation notes written by another practitioner (unlicensed practitioner) for 1 out 15 visits.

ii. SB filled his prescriptions at the Walgreens in Berlin, CT.

1. From November 2008 through March 2009, SB paid $29,427.77 in cash for his prescriptions of Fentora and Alprazolam written by the Respondent.
2. All other prescriptions were paid with insurance (CTMED and/or AARPMPD).

iii. From July 2008 through October 2009 the police department responded to 19 calls regarding SB's inability to get up from a fall on his own. Six out of the 19 calls resulted in SB being transported to the hospital for an evaluation.

iv. From July 2008 through August 2009, SB had seven inpatient hospitalizations related to frequent falls, UTI and narcotic overdose.

v. In February 2003 SB under went bilateral shoulder replacement.

b. The medical records (Respondent's office records) from July 2008 through October 2009 identified the following:

i. The medical record identified that SB had diagnoses that included Degenerative Arthritis of shoulders, Major Depression, Panic Disorder, GERD, Obesity, Hepatitis C, Opioid Addiction, and HTN.

ii. In July 2008 the Respondent wrote prescriptions for Fentora 4800mcg /24, Valium 60mg/24, and Methadone 480mg/24.

iii. In August 2008 the Respondent added Xanax 8mg/24 and in October 2008 Percocet 60mg/24 was added.

1. During an office visit on February 23, 2009, the Respondent documented that SB appeared with affect sedated and sluggish secondary to taking Fentora and had to wait in the office before driving home.

iv. By May 2009, the Respondent prescribed Xanax 8mg/24, Methadone 140mg/24 and Dilaudid 40mg/24 to SB.

v. On September 3, 2009 after six weeks of hospitalization and rehabilitation services in which his narcotic pain medications were not prescribed, the Respondent wrote SB a prescription for Methadone 40mg/24 and wrote multiple prescriptions for Methadone 80mg/24 at one time. A prescription for Xanax 1mg/24 was also written.
    1. During this time period, the Respondent prescribed Seroquel, Wellbutrin, Abilify and Lamictal. In addition, he wrote prescriptions for Lisinopril, Loratadine, Metoprolol, Nexium, Norvasc and Soma.

c. The pharmacy records from July 2008 through October 2009 identified the following:

i. The address on record identified that SB lived in Berlin, CT with his wife, Patient I (PB).

ii. SB filled his prescriptions at the Walgreens in Berlin, CT.
    1. From November 2008 through March 2009, SB paid $29,427.77 in cash for his prescriptions of Fentora and Alprazolam written by the Respondent.
    2. All other prescriptions were paid with insurance (CTMED and/or AARPMPD).

iii. The medical record lacked documentation for the following prescriptions written by the Respondent that were filled by SB:
    1. August 18, 2008 = Methadone 10mg (24) written on July 9, 2008.
    2. November 5, 2008 = Xanax 2mg ½ tablet QID (60) 1 refill.
        i. The pharmacy search identified three prescriptions written on November 5, 2008 were filled and the medical record identified only two prescriptions written.
    3. March 22, 2009 = Abilify 10mg (30).
    4. April 23, 2009 = Methadone 10mg 11 tablets QID (220).
        a. Written on April 23, 2009 for fill date of May 3, 2009.
            i. The pharmacy search identified three prescriptions written on April 23, 2009 were filled and the medical record identified only two prescriptions written.

iv. The medical record lacked documentation for the following prescriptions written by the Respondent that were presented to the Walgreens pharmacy but not filled by SB:
    1. July 7, 2008 = Valium 10mg (90) for 10 days.
    2. July 9, 2008 = Fentora 800mcg (56) for 9 days.
    3. July 15, 2008 = Fentora 600mcg (240) for 5 days and
        i. Fentora 600mcg (56) for 10 days and
        ii. Methadone 10mg (170) for 7 days.
    4. August 28, 2008 = Methadone 10mg (220) and
        i. Fentora 800mcg (56).
    5. October 13, 2008 = Methadone 10mg (220) for 5 days.
    6. October 17, 2008 = Dilaudid 8mg (40) for 10 days.
    7. November 5, 2008 = Methadone 10mg (220) for 5 days and
        i. Fentora 800mcg (56) for 9 days.
    8. December 9, 2008 = Xanax 2mg (60) and
        i. Xanax 2mg (60).

v. The pharmacy records lacked documentation that the following prescriptions written by the Respondent were filled by SB:
    1. August 6, 2008 = Fentora 800mcg 1 tablet every 4 hours (56).
        i. Methadone 10mg 11 tablets QID (220).
        ii. Methadone 10mg 11 tablets QID (220).
        iii. Methadone 10mg 11 tablets QID (220).

2. September 3, 2008 = Fentora 800mcg 1 tablet every 6 hours, PRN (56).
    i. Methadone 10mg 11 tablets QID (220).
    ii. Methadone 10mg 11 tablets QID (220).
3. October 8, 2008 = Fentora 800mcg 1 tablets every 6 hours, PRN (56).
    i. Methadone 10mg 11 tablets QID (220).
4. October 13, 2008 = Norco 10/325mg 2 tablets every 6 hours (60) 3 refills.
    a. (Only 1 of the 4 scripts was filled on October 14, 2008).
        i. Methadone 10mg 11 tablets QID (220).
5. November 5, 2008 = Methadone 10mg 11 tablets QID (220).
    i. Methadone 10mg 11 tablets QID (220).
6. December 9, 2008 = Methadone 10mg 11 tablets QID (220).
    i. Methadone 10mg 11 tablets QID (220).
    ii. Methadone 10mg 11 tablets QID (220).
7. February 5, 2009 = Methadone 10mg 11 tablets QID (220).
    i. Fentora 800mcg 1 tablet every 6 hours, PRN (56).
8. February 23, 2009 = Fentora 800mcg 1 tablet every 6 hours, PRN (56).
    i. Fentora 800mcg 1 tablet every 6 hours, PRN (56).
9. June 18, 2009 = Methadone 3 tablets TID, 5 tablets QHS (100).

Comment by Investigator: The Department was unable to verify whether one prescription was presented numerous times and rejected at each attempt by the pharmacy or multiple prescriptions were presented and also rejected. Possible reasons include but are not limited to insufficient insurance benefit or payment source. An interview with corporate pharmacy personnel could not establish or verify a particular reason for which prescriptions were not filled. Therefore, it remains an unknown.

vi. The Respondent wrote a prescription for Methadone 10mg (220) for 5 days on April 23, 2009 with a note that identified, "To fill on May 3, 2009. Patient with refractory pain, post bilateral shoulder reconstruction."
vii. The Respondent wrote a prescription for Methadone 10mg (100) for 7 days on June 18, 2009 with a note that identified, "To fill on July 9, 2009. Patient with refractory pain, post bilateral shoulder reconstruction."
viii. The Respondent wrote a prescription for Methadone 10mg (30) for 5 days on September 3, 2009 with a note that identified, "Patient with refractory pain, post bilateral shoulder reconstruction."
ix. The Respondent wrote a prescription for Methadone 10mg (60) for 7 days on October 1, 2009 with a note that identified, "Patient with refractory pain, post bilateral shoulder reconstruction."
x. The pharmacy records identified that from December 8, 2008 through December 10, 2008 (3 days), SB filled the following prescriptions:
    1. Fentora 800mcg for a total of 116 tablets.
    2. Methadone 10mg for a total of 440 tablets.
    3. Xanax 2mg for a total of 60 tablets.
        a. The police records (Exhibit Me) identified that they were called to SB's home on December 14, 16, and 20, 2008 because he had fallen and could not get up.
xi. The pharmacy records identified that form June 25, 2009 through July 9, 2009 (14 days), SB filled the following prescriptions:
    1. Dilaudid 8mg for a total of 135 tablets.
    2. Methadone 10mg for a total of 300 tablets.

3. Xanax 2mg for a total of 60 tablets.
4. Abilify 10mg (antipsychotic) for a total of 30 tablets.
5. Budeprion XL (Wellbutrin) (antidepressant) for a total of 30 tablets.
    a. The police records (Exhibit Me) identified that they were called to SB's home three times in a 24-hour period from July 11, 2009 through July 12, 2009.
        i. On July 12 and 16, 2009, SB was transported to the hospital for an evaluation due to mental status changes secondary to taking numerous narcotic medications.

d. The PCP office records from June 2008 though August 2009 identified the following:

i. SB was seen as a new patient on June 16, 2008 with a problem list that included falls, urinary incontinence, HTN and a history of Hepatitis C.
    1. The treatment plan included to discontinue the Soma secondary to dizziness, which resulted in falls, and to avoid sedatives.
    2. Blood work and a urinalysis were also ordered.

ii. The PCP signed paperwork for services from the Visiting Nurse Association (VNA) subsequent to a hospitalization on July 16, 2008 from a fall.
    1. The hospital discharge summary dated July 19, 2008 identified that a CT Abdominal Scan identified a defect at the level of the distal bile duct which could be secondary to a small tumor and that the common bile duct was dilated.
        a. The Gastroenterology service identified that the dilatation of the common bile duct may be secondary to chronic opioid use.

iii. The September 26, 2008 office visit was a follow up appointment subsequent to the completion of the VNA services.

iv. A note dated August 26, 2009 identified that SB had been discharged from a three-week stay for rehabilitation for imbalance and poly substance abuse. The plan was identified as SB would call the PCP in three weeks for medication refills.

e. The Berlin Police Reports from June 2008 through October 2009 identified the following;

i. From July 2008 through July 2009, the Berlin Police Department responded to 22 calls at the home of SB.
    1. Of the 22 calls, 20 calls were identified with the primary complaint listed as SB had fallen and could not get up.
        a. From July 11, 2009 through July 12, 2009, the Berlin Police Department responded to three calls at the home of SB within a 24-hour period.
            i. SB was found on the floor and was unable to get up each time.
            ii. On July 12, 2009, SB was also found to be confused, had taken 56 out of 60 tablets of Xanax since July 2, 2009 and was transported to the hospital for an evaluation.
        b. On July 16, 2000 the Berlin Police responded to a call that SB had fallen and could not get up.
            i. SB was found on the floor, confused and covered in urine and feces.
    2. Of the 19 calls, 6 calls resulted in the transportation of SB to the hospital for an evaluation.
        a. SB was often found on the floor, incontinent of urine, confused and disoriented to time, place and had taken numerous pain medications.

ii. On October 13, 2009 the Berlin Police Department responded to a call the identified that SB had been found on the floor and was unresponsive by a family member.

f. The Hospital of Central Connecticut (NBGH) from March 2009 through July 2009 identified the following:

i. The January 13, 2009 Emergency Room (ER) admission identified the following;
   1. SB present with police papers requesting an evaluation secondary to self-medicating with Seroquel and Fentora. SB was found on the floor and unable to get up. The police reported that they had been to the home of SB 12 times in the last 3 months for lift assist.
      a. SB identified that he had taken an overdose of medication to help him sleep and that he called his own med-alert for unsteady gait, severe dizziness and the inability to stand after taking Fentanyl and Seroquel.
      b. SB denied suicide or homicide ideation but admitted that were it not for his daughter, he would have taken his life 2 days after his wife died.
      c. SB was discharged home after the sedation of the medications cleared and SB denied suicide or homicide ideation.

ii. The March 4 – 9, 2009 admission identified the following:
   1. SB was admitted after a fall that left him lying on the floor with mental status changes after taking a large amount of pain medications.
      a. The discharge summary dated March 9, 2009 identified that SB was treated for Cellulitis and his medications were adjusted.
         i. The Valium, Soma, Depakote, and Fentora were discontinued and the daily Methadone dose was lowered.
      b. Discharged medications included Keflex 500mg x 8 days, Lopressor 100mg BID, Loratadine 10mg QD, Wellbutrin XL 300mg, Nexium 40mg QD, Norvasc 5mg QD and Methadone 10mg BID.

iii. The March 19 - 27, 2009 admission identified the following:
   1. SB was admitted to W1 secondary to falling out of bed and not being able to get up after taking a large amount of methadone
      a. The discharge summary dated March 27, 2009 identified that SB's Methadone was lowered to 10mg BID and a recommendation to follow another physician for pain management was made.
      b. Discharge medications included Lopressor 100mg BID, Loratadine 10mg QD, Wellbutrin XR 300mg QD, Nexium 40mg QD, Norvasc 5mg QD, and Methadone 10mg BID.

iv. The May 5-8, 2009 admission identified the following:
   1. SB was admitted with mental status changes after a fall that left him lying on the floor covered in urine and feces for 3 days.
      a. The discharge summary dated May 8, 2009 identified that SB was treated for a UTI, his medications were adjusted, the Soma was discontinued, and SB would be discharged to home with VNA services to monitor his blood pressure.
      b. Medications at discharge included Bactrim DS BID x 5 days, Metoprolol 100mg TID, Lisinopril 20mg QD, Seroquel 300mg QHS, Wellbutrin XL 300mg QD, and Methadone 30mg QAM and 10mg QHS.

v. The July 12, 2009 ER admission identified the following:

1. SB presented to the ER with severe depression secondary to not taking his antidepressants, taking too many pills and confusion about what pills to take. SB also presented with a large ecchymotic area on the left side of his forehead secondary to a fall.
    a. SB refused a recommendation to be admitted for physical therapy and gait training.
    b. SB was discharged to home.

vi. The July 16 – 22, 2009 admission identified the following:
1. SB was admitted in part with chronic equilibrium problem, frequent falls, depression disorder and an overdose of medications.
    a. The discharge summary dated July 22, 2009 identified that SB had stopped all of his medications "on his own" to see how he would do prior to his admission on July 16, 2009.
    b. His blood pressure medications were adjusted as SB was bradycardic on admission and his Methadone medication was not restarted.
2. SB was discharged to the Rocky Hill Skilled Nursing and Rehabilitation facility.
    a. Medications at discharge included Metoprolol 50mg BID, Norvasc 10mg QD, Lisinoril 20mg QD, Miralax 17gm QD, Xanax 2mg QID, Seroquel 300mg QHS, and Wellbutrin XL QD.

g. The Rocky Hill Skilled Nursing and Rehabilitation Center RHSNRC) facility records from July 23 – 30, 2009 and from August 10 – 24, 2009 identified the following:

i. From July 23 – 30, 2009 the facility records identified the following:
1. SB was admitted for short-term rehabilitation.
2. SB was evaluated by physical therapy and the treatment plan consisted of exercises to increase independence with ambulation five times a week for a period of four weeks.
    a. During the evaluation period, SB developed episodes of psychosis, delusional thinking with auditory and visual hallucinations.
3. SB was sent to Hebrew Health Care (HHC) on a physician's emergency paper (PEC).

ii. From August 10 - 24, 2009 the facility records identified the following:
1. SB was readmitted from HHC in a stable mood after medication adjustments.
    a. Medication adjustments included Abilify 5mg QD, Seroquel 250mg QHS, Neurontin 200mg TID, Xanax 0.5mg BID, PRN for anxiety, Wellbutrin SR 150mg BID, and Melatonin 6mg QHS.
2. SB was re-evaluated by physical therapy and the treatment plan to increase independence with ambulate was resumed.
    a. The facility notes identified that SB denied pain and that the medication regime was effective without Methadone.
    b. The physical therapy discharge note identified that SB had progressed to full independence with all activities of daily living (ADLs) and mobility.
    c. Discharge medications listed on the W-10 included Neurontin 200mg TID, Omeprazole 20mg QD, Xanax 1mg QHS, Xanax 0.5mg BID, Seroquel 25mg QHS, Folic Acid 1mg QD, Thiamine 100mg QD, Melatonin 6mg QHS, Lisinoril 20mg QD, Xanax 0.5mg every 12 hours, PRN, Norvasc 10mg QD, Abilify 5mg QD,

Lamictal 25mg QD, Wellbutrin SR 150mg BID, Senna 1 tablet BID, Lopressor 50mg BID and Miralax 17gm BID.

h. The Hebrew Health Care (HHC) facility records from July 30 – August 10, 2009 identified the following:

i. SB was admitted on a fifteen day PEC due to increased delusional thinking, auditory and visual hallucinations and striking out at staff.

1. Medications were adjusted and Lamictal and Abilify were added to stable mood.
    a. The Xanax daily dosage was decreased and Melatonin was added to help with insomnia.
    b. Neurontin was added to aid with chronic pain control.
        i. The medical record identified that SB responded well with this medication regime, became more wakeful during the day, ate and slept well.
            1. The medical record also identified that SB expressed a wish to avoid medications with abuse potential.
2. The discharge summary dated August 10, 2009 identified that SB was returning to RHSNR in a stabile mood with recommendations to continue with the present medication regime.
    a. Discharge medications included Abilify 5mg QD, Seroquel 250mg QHS, Neurontin 200mg TID, Xanax 0.5mg BID, PRN for anxiety, Wellbutrin SR 150mg BID, and Melatonin 6mg QHS.

i. The final Berlin Police Report for the October 13, 2009 call identified the following:

i. The Berlin Police responded to a call on October 13, 2009 from a family identifying that SB was found on the floor and was unresponsive at approximately 5:35PM.

1. The Berlin Police upon arriving to the home of SB, did not see any obvious signs of injury or trauma that may have caused the death, nor was any furniture or other items disturbed indicating a struggle had taken place.
    a. SB was noted to be lying face down with his arms stretched out over his head and a small pool of blood/fluid substance was directly under SB's mouth/nose area.
        i. SB was wearing a watch, a necklace, a gold colored bracelet and no clothing.
    b. Rigor Mortis was noted to have set in and Lividity was present in the facial area.
2. The Berlin Police noted a very large quantity of prescription drugs in the kitchen area.
    a. An inventory identified twenty-three (23) prescription drug containers with various amounts ranging from full, partially full and empty.
        i. SB's PCP, a physician's assistant, the Respondent and a physician that treated allergies were the names identified on the prescription bottles.
    b. The prescriptions written by the Respondent were identified as the following:
        i. Thirty of the 30 pills of Budeprion 300mg QD written on November 30, 2008 remained.
        ii. Thirty of the 30 pills of Budeprion 300mg QD written on December 24, 2008 remained.

iii. None of the 60 pills of Alprazolam 2mg QD written on November 28, 2008 remained.
iv. None of the 60 pills of Methadone 10mg 4 tablets BID written on October 8, 2009 remained.
v. Three of the 60 pills of Budeprion 300mg BID written on September 11, 2009 remained.
vi. Thirty of the 30 pills of Lamotrigine 25mg TID written on October 7, 2009 remained.
vii. Twenty-three and a half of the 30 pills of Budeprion 300mg QD written on October 9, 2009 remained.
viii. An assorted mix of broken pills remained of Abilify 5mg.
ix. Fifty-four and a half of the 60 pills of Seroquel written on October 1, 2009 remained.
x. One hundred ninety seven of 180 pills of Metoprolol Tartrate 100mg QD written on September 9, 2008 remained.
xi. Ninety-two of the 30 pills of Budeprion 300mg QD written on January 22, 2009 remained.
xii. None of the 30 pills of Alprazolam 1mg QD written on September 9, 2009 remained.
xiii. Thirty of the 30 pills of Abilify 10mg QD written September 29, 2009 remained.

j. The autopsy report identified the following:

i. The autopsy report dated January 14, 2010 identified the final cause of death determined to be natural from hypertrophic dilated cardiomyopathy with cirrhosis and obesity.

k. Dr. Power's report identified the following:

i. He supported the findings of the autopsy report.

l. The Respondent identified the following in his statement regarding the allegations presented by the Department:

i. The Respondent identified that SB had a diagnosis of mixed bipolar disorder, degenerative disc disorder, degenerative arthritis of the shoulders, status post bilateral shoulder arthroplasty (2003), hepatitis B and C, GERD, hypertension and obesity.
    1. SB had been a patient since 2001 and suffered from chronic pain, recurrent episodes of depression with a history of heroin addiction and a history of being sober since 1977.
ii. The Respondent identified that since 2002, SB's daily medication regiment included Methadone 160mg, Oxycontin 320mg, Valium 40mg and Soma 1 to 2 tablets TID, PRN.
    1. In 2004 the Methadone was increased to 200mg/24 and was increased to 240mg/24 in 2005.
        a. In November 2006 the Oxycontin was discontinued due to insurance coverage and the Methadone was increased to 480mg/24.
        b. In January 2008 Fentora 800mcg up to 4 tablets daily was added.
iii. The Respondent identified that after SB was discharged from a hospitalization to evaluate dizziness and falls at home in August 2008, Xanax 2mg QID was added to replace the Valium 10mg every four hours and the Methadone was reduced to 440mg daily.
    1. The Respondent identified that all the tests conducted were normal (EKG, mental status examinations) but did identify cardiomegaly on chest x-ray

and hepatosplenomegaly with dilation of the ducts possibly as a result of the chronic opiate treatment on an abdominal CT Scan.

a. The Respondent further identified that opioid agonists and benzodiazepines are not contraindicated in patients with cardiac or hepatic difficulties.

iv. The Respondent identified that the police and family members did not contact him regarding the motor vehicle accidents or the frequent falls at home.

1. The Respondent identified that hospital staff did contact him during hospitalizations to verify dosage and he recommended sufficient opiates to prevent withdrawal and provide sufficient comfort.
2. The Respondent identified that after the March hospitalization, the dosage of the Xanax and Fentora were reduced and the Methadone was maintained.
3. The Respondent identified that after the May hospitalization, the Methadone was reduced to 140mg daily, Dilaudid was prescribed to replace the Fentora and the Soma was discontinued.

v. The Respondent identified that after the July hospitalization, SB requested that the opioid analgesic be re-initiated because he discovered that independent living was much more demanding that his nursing home experience.

1. The Respondent identified that he agreed to slowly and carefully resume opioids only after consulting with his family and alerting his PCP (Dr. Robinson).
2. The Respondent identified he call Dr. Robinson and had a long conversation with SB's daughter who agreed to the treatment plan and felt her father was suffering.
    a. The Respondent identified that his note of August 8, 2009 documented his conversation with SB's daughter.

m. The Consultant identified the following in her report:

i. The Consultant opined that the Respondent did not meet the community standard of care for patient SB in the following areas:

Documentation:

1. Documentation that lacked any objective data or objective indicators (physical exam, mental status exam, the patient's condition and behavior) that would justify the medication prescribed.
    a. The Consultant identified that the community standard is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including formation from other sources, such as prior treatment records, an objective assessment of the complaint, such as physical examination, mental status examination, testing, or other objective measure of the problems presented.
        i. Then a clear assessment of the diagnosis is made with a detailed plan of care and follows up.
    b. The Respondent's treatment plans do not reflect symptoms reported, are unclear due to brevity, lack sufficient detail, and the care appears to be driven by patient request.
        i. The medical record lacked any details of the prescribed medication regimes and it is not possible to determine from reading the entries what the exact prescribed therapy is or how it relates to the patient's self report.

c. The Consultant identified that it is not the community standard to prescribe large doses of opiate medication to treat pain based solely on the patient's report of pain, the patient's report of interventions by other physicians, and psychosocial complaints rather than objective assessments of a response to treatment.
d. The Consultant opined that this is a moderate deviation from the standard of care as other community physicians may have less than ideal documentation but in the Respondent's case, good documentation is even more important to justify the deviation from the standard.

Assessment:

1. Failure to assess the response to treatment through standard measures utilized in monitoring the response of chronic pain to treatment.
    a. The Consultant identified that is the community standard to continually monitor the patient's response to treatment with objective or structured subjective measures and to strive to maintain the patient on the lowest dose possible of the opiate medication.
    b. The Consultant identified that the Respondent's documentation failed to identify that he provided alternative pain interventions and failed to explain the risks, benefits and alternatives to treatment to SB.
        i. The medical records identified SB's difficulty with falls and frequent hospitalizations but the Respondent does not coordinate the patient's care with other treatment providers.
        ii. The Consultant identified that most disturbing is that in August and September 2009 when the Respondent's notes demonstrate that he is aware that SB was taken off of the scheduled II narcotics that were most likely responsible for his multiple falls and altered mental status, the Respondent resumes prescriptions of Methadone and other sedating medications.
    c. The Consultant identified it is not the community standard of care to continue to resume narcotics and continue to prescribe high doses of opiate medication in addition to other medications that result in sedation and respiratory distress, after a patient has had multiple police interventions, emergency room visits, and hospital admissions for falls, altered mental status, and psychosis due to opiate toxicity and addiction.
    d. The Consultant opined that this failure to assess is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of SB's dependence on opioid medication.

Evaluation:

1. Prescribing high doses of opiates to a patient that is drug addicted and suffered many adverse events due to this addiction.
    a. The Consultant identified that it is the standard of care to carefully prescribe scheduled II controlled substances to any patient, especially one with a history of addiction.
    b. The Consultant identified that it is the standard of care to ensure that the patient is not misusing or abusing the medication.

i. The hospital records of July 2009 identified that SB was admitted after an overdose of Xanax.
ii. The medical record identified that after a prolonged detoxification and nursing home rehabilitation, SB resumed treatment with the Respondent in August 2009.
iii. The medical record identified that the Respondent placed SB on a complicated medication regimen.
1. The medical record further identified that the Respondent prescribed opiate medication, along with antipsychotic medication, antidepressant medication, benzodiazepine medication (the exact medication SB had previously overdosed on), and anticonvulsant medication.
2. The Consultant identified that all these medications in combination present the same propensity for mental confusion, gait instability, and toxicity that SB had experienced previously when he was falling regularly and experienced multiple hospital admissions for altered mental status.

c. The Consultant opined that this is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II controlled medications to a clearly dependent patient is a serious disservice to the patient.

Prescribing Practices:

1. Prescribing excessively high doses of schedule II controlled substances in increasing amounts to a clearly dependent patient and in combination with other addictive and sedative medications without addressing tolerance and potential lethal toxicity.
a. The community standard is to prescribe much lower doses of medication and for a defined length of time.
i. The medical record identified that between September 3, 2009 until his death on October 13, 2009, SB was prescribed and filled the following prescriptions:
1. One hundred fifty (150) pills of Methadone 10mg.
2. Sixty (60) pills of Lamotragine 25mg.
3. Thirty (30) pills of Abilify 5mg.
4. Thirty (30) pills of Xanax 1mg.
5. Ninety (90) pills of Seroquel 300mg.
6. Sixty (60) pills of Buproprion SR 150mg.
7. Thirty (30) pills of Buproprion XL 300mg.
ii. According to the Consultant, the medical record was unclear as to why the Respondent began prescribing multiple medications again, just prior to the patient's death, with significant toxic effect to SB after he had successfully been taken off medication with a positive effect.
iii. The Consultant opined that it is substandard care to prescribe schedule II controlled medications for unclear indications.

b. The Consultant opined that this is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose.
    1. The Consultant identified that unfortunately SB died after a long documented history of adverse outcomes due to narcotics addiction.

N. A sworn statement was received on September 21, 2009 from the daughter of PB and SB, Jessica Bitgood (Exhibit N).

a. Ms. Bitgood identified the following in her statement:
    i. She is the daughter of Patient J (SB).
    ii. Her mother, Patient I (PB) died on November 27, 2008.
        1. Within a few weeks of her mother's death, her father was involved in several car accidents.
    iii. Since the time of her mother's death, she noticed that her father became very depressed, refused calls from family members and refused to attend to his ADLs.
        1. The family obtained a medical alert button after he began to experience numerous falls in which he was unable to get up on his own.
        2. The falls began to occur on a daily basis and Ms. Bitgood noticed that her father was on a lot of medications for depression and pain along with other health related issues.
            a. On numerous occasions, Ms. Bitgood observed that her father couldn't stand up straight or walk without shaking and he would often slur his words.
                i. During one of her visits, her father informed her that he was upset with the Respondent for making him wait in the waiting room for over an hour because the Respondent didn't think he could drive safely.
            b. On numerous occasions, she would call 911 for assistance when she found her father on the floor.
        3. She began to get daily calls from the Berlin Police regarding her father's falls and the condition in which the police found him.
            a. The police began to send her father to the hospital for an evaluation.
    iv. Her father was admitted to the psychiatric unit for detoxification for about a week from one of the calls that the police responded to regarding his falls and inability to get up.
        1. She identified that a family intervention was conducted and she expressed her concerns regarding the amount of pain medication her father was prescribed.
            a. She informed the staff that she felt her father needed help to get off all pain medications.
            b. Her father did well off the medications but would return to the Respondent's office and obtained more pain medications.
                i. After each hospital visit, her father would improve when he was off the pain medications and then would get worse after he resumed his pain medications.
    v. She identified that things got so bad with her father deteriorating health that she sought legal advise and obtained the power of attorney and became the conservator of her father's health in June 2009.

1. As the power of attorney and the conservator of her father's health, she identified that she had her father admitted to Rocky Hill Rehabilitation Center (RHSNRC) for occupational and physical therapy.
    a. She identified that her father was so weak during the last hospital admission in July 2009 that he could not walk on his own.
        i. Her father had told her that he had tried to stop taking the Methadone on his own the weeks prior to his hospitalization in July 2009.
        ii. She identified that the withdrawal from the Methadone caused a few problems at RHRC and he was transferred to Hebrew Home.

vi. She identified that after her father completed his detoxification and rehabilitation, she saw a great improvement and a whole new person.
    1. Her father had been taken off all narcotic pain medications and reported no pain with the new medication regime prescribed.

vii. She identified that her father went back to the Respondent's office in September 2009 and on September 3, 2009, the Respondent called her to discuss her father's medication regime.
    1. She identified that the Respondent had asked her how she wanted him to proceed with her father's medications.
        a. She identified that she told the Respondent that he was the physician and that he should make the right decision with her father.
        b. She identified that she told the Respondent that given all the hospital stays and police reports, she did not want her father going backwards.
            i. She further identified that she informed the Respondent that she saw a great improvement in her father with the new medication regime instituted by RHHC.

O. A sworn statement was received on September 21, 2009 from the daughter of PB and SB, Jessica Bitgood (Exhibit O).

a. Ms. Bitgood identified the following in her statement:
    i. She is the daughter of Patient I (PB), who is now deceased.
    ii. She identified that things took a turn for the worse in January 2005 when her grandmother (her mother's mother) died.
        1. She identified that her mom was admitted to the New Britain General Hospital psychiatric unit shortly after that and her mother was never the same person after that admission.
    iii. She described her mother as having a lot of medical issues, lots of pain and severe depression.
        1. Her mother was always heavily medicated on pain pills, depression pills and lots of other medications.
        2. Ms. Bitgood identified that she had always wondered how one person could be on so much medication.
    iv. On November 27, 2008, her brother called her to inform her that their mother had died.
        1. She identified that when she arrived at her parent's home, the police were there and they were treating it like a crime scene.
        2. She identified that the police found numerous pill bottles around the house and collected them for their report.

v. She identified that she requested and obtained a copy of the police report and the autopsy report.

P. A copy of the CLIA (Clinical Laboratory Improvement Amendments) waiver violation was obtained on December 9, 2009 from the Department's Supervising Medical Laboratory Consultant, John J. Murphy (Exhibit P).

a. The CLIA waiver violation identified the following:

i. The Respondent had hired a laboratory employee from Calloway Laboratory to conduct urine toxicology screens at his office located at 26 Chamberlain Highway, Berlin, CT since about February 2008.

1. The Calloway Laboratory employee had been performing urine drug testing on site with an Instacup test kit without a CLIA certificate.

ii. On December 9, 2009, the Respondent submitted an application for a CLIA certification to the Department.

1. The application identified that an estimated total annual test volume was listed as 52,800.

iii. As of July 1, 2010, the investigation into the CLIA waiver violations is still pending.

Q. A copy of the police report regarding the arrest of DS was received on December 15, 2009 from the Berlin Police Department (Exhibit Q).

a. The Berlin Police Report identified the following:

i. An investigation was conducted based on a report that one of the Respondent's patients, DS, had been observed selling her prescriptions of Percocet to an unknown white male.

1. The investigation led to an arrest warrant issued on September 18, 2009 for DS.

a. The charges were identified as the following:

i. Illegal sale of Narcotics by a Non-Dependent Person.

ii. Failure to keep Narcotics in the Original Container.

2. DS went to the Berlin Police Department on September 24, 2006 to turn herself in.

ii. An arrest warrant for the unknown white male later identified as WB, was submitted to the Mid-State Narcotics Task Force.

1. A discussion with a representative of the State's Attorney's Office resulted in the arrest warrant denied and the investigation terminated.

R. A written statement regarding the results of the autopsy reports was received on February 2, 2010 from the Director of the State of Connecticut Controlled Substances Toxicology Laboratory, Robert H. Powers, PhD, DABFT (Exhibit R).

a. Dr. Powers identified the following in his statement:

i. He supported the findings of the Forensic Pathologist regarding Patient I (PB) and Patient J (SB). (See Exhibits L and M).

S. A written statement responding to the allegation letter was received on March 23, 2010 from the Respondent's attorney, Richard C. Tynan (Exhibit S).

a. The Respondent identified the following in his statement:

i. In regards to the concerns presented by DCD, the Respondent provided an insight into his overall management style and philosophy of pain management.

ii. In regards to the allegations presented by the Department, see Exhibits D through M.

T. A copy of the Consultant's Report was received on June 2, 2010 and an addendum was received on July 19, 2010 (Exhibit T). (A copy of the Consultant's Report is enclosed and discussed in Exhibits D-M).

a. The Consultant's Report and addendum identified the following:

i. The Consultant opined that the Respondent did not meet the community standard of care in the areas of professional ethics, documentation, assessment, evaluation, and prescribing practices for 6 out of the 10 patient records reviewed (See Exhibits D, E, H I, J, and K).
ii. The Consultant opined that the Respondent did not meet the community standard of care in the areas of documentation, assessment, evaluation, and prescribing practices for all 10 patient records reviewed (See Exhibits D-M).
iii. The Consultant opined that there is a clear pattern of substandard medical care provided by the Respondent that is grossly below the community standard.
    1. The Consultant further opined that the Respondent's substandard care has resulted in patient death, serious adverse outcomes, and criminal investigations.
iv. The Consultant supported her findings with numerous excerpts from published books, journal and website articles written by experts in the field as identified in the following:
    1. Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition, Lippincott, Williams, and Wilkins Publisher, 2003
    2. Bates Guide to Physical Examination and History Taking, Lippincott, Williams, and Wilkins, Ninth Edition, 2007.
    3. "Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40", U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, MD, PhD, Consensus Panel Chair, 2004.
    4. Goldman, Kelly's Textbook of Internal Medicine, Second Edition, J.B. Lippincott Company, 1992.
    5. U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, "Drugs and Chemicals of Concern, Oxycodone", October 2009, usdoj.gov.
    6. Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005.
    7. Medscape, Nature Reviews Rheumatology, "Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: April 1, 2010.
    8. U.S. Food and Drug Administration, WWW. FDA.gov, 2010.
    9. Drugs.com, 2010, Drug Information on Line.
    10. The Federation of State Medical Boards of the United States, Inc., Model Policy for the use of Controlled Substances for the Treatment of Pain, 2004.
    11. The American Pain Foundation, Consensus Statement in Support of H.R. 1020, the National Pain Care Policy Act of 2005.

Statement of Findings:

1. The Department of Consumer Protection, Drug Control Division (DCD) report identified numerous concerns regarding the Respondent's prescribing practices.
2. The Department reviewed 10 patient records regarding the care and services provided by the Respondent. During the investigation, the Department accessed the Respondent's office records, pharmacy records, dental records, PCP records, and hospital records. A review of these records identified the following concerns:

a. For all his patients, the Respondent prescribed high doses of schedule II controlled substances and in large quantities with little to limited documentation regarding the patient's clinical presentation.
b. For many of his patients, the Respondent also prescribed Suboxone with high doses of opiates and/or benzodiazepines.
c. For many of his patients, the records lacked documentation that the Respondent consulted with his patients' dentist or their PCP prior to prescribing large amounts of schedule II controlled substances for pain.
d. For several of his patients, the records identified hospital admissions secondary to health issues and/or medical complications from over use of opiates.
e. For several of his patients, the records identified that the Respondent was contacted during the hospital admission for verification of the scheduled II control substance dosage.
    i. Even though his patients were discharged with lower doses of scheduled II controlled substances for pain, the Respondent would resume prescribing them in high doses and large quantities upon discharge.
f. For several of his patients, the records identified that they utilized multiple providers to obtain additional schedule II narcotic medications in addition to the ones prescribed by the Respondent.
g. For many of his patients, the records identified that they utilized numerous pharmacy chains in different towns to fill prescriptions written by the Respondent.
h. For many of his patients, the records identified that they alternated paying for their prescriptions written by the Respondent with different insurances and cash.
i. For many of his patients, the records lacked documentation for prescriptions filled and/or for prescriptions presented to the pharmacy but not filled by the patients.

3. During the investigation, the Department accessed medical records from skilled nursing homes. A review of the skilled nursing home records identified the following:
    a. For one of his patients, the records identified that the patient was admitted secondary to complications of opiate over use and was detoxed from all schedule II narcotic pain medications.
4. During the investigation, the Department accessed multiple police reports. A review of the police records identified the following:
    a. For one of his patients, the police made numerous house calls secondary to falls and over sedation from schedule II narcotic medications.
    b. For one of his patients, the police assisted in transporting the patient to the hospital for an evaluation a total of 6 times secondary to mental status changes from opiate over use.
    c. For one of his patients, the police made an arrest secondary to the patient selling prescriptions written by the Respondent.
5. During the investigation the Department accessed two autopsy reports. A review of the autopsy reports identified the following:
    a. For one of his patients, the autopsy report identified the untimely death was a result of opiate toxicity.
    b. For one of his patients, the autopsy report identified the untimely death was a result of natural causes, which occurred shortly after the Respondent restarted the schedule II controlled substances that this patient had been detoxified from at the skilled nursing home.
6. During the investigation, the Department obtained sworn statements from the daughter of two the Respondent's patients. The daughter identified that she believed both parents were prescribed too much pain medication and that both parents died under the care of the Respondent. After her mother's death, she identified that she became so concerned about her father's health that she sought and obtained the power of attorney over his health issues. As power of attorney, she admitted him to a facility that detoxed him off all schedule II narcotic pain medications. Her statement regarding the

conversation she had with the Respondent regarding her father's medications after his detoxification contradicts what the Respondent identified in his response to the Department's allegation letter. She identified that she told the Respondent that her father was a different person off the narcotics, had been doing well without the narcotics for pain and that she did not want him to go back to the way he was prior to his detoxification off all pain medications.

7. The Respondent via his attorney provided the Department with a written statement. He did not address the allegations made by the DCD but provided a summary of his credentials and his philosophy of treatment chronic pain management clients. His responses to the Department's allegations and concerns basically stated that his care is nothing less than what is the standard practice in the community of practitioners treating chronic pain individuals. Urine toxicology screens that test positive for medications not prescribed by him are described as behaviors consist with inadequate pain relief and/or possible dietary intake, i.e., poppy seeds. He described urine toxicology screens that tested positive for illicit street drugs as behaviors that are not "nefarious". According to the Respondent, these clients should be offered more treatment rather than to punitively withhold treatment. In addition, the Respondent doesn't feel it is his responsibility to report or to consult with his patient's other treating providers (PCP, Dentist, etc.) as he expects his clients to share this information with their other providers. Nor does he feels it is his responsibility to monitor the habits of his clients regarding where they are filling their prescriptions, if they are filling all their prescriptions prescribed by him, if they are utilizing their Department of Social Services (DSS) contracted pharmacy, and whether or not they are obtaining other controlled substances from other providers. He identified that often times, his clients' insurance would not cover all their prescriptions and he supported their efforts to shop around to get the best deal.
8. The Consultant provided the Department with a report. The Consultant identified in her addendum that the new information reviewed did not change her original opinion. The Consultant opined that the Respondent did not meet the community standard of care in the areas of professional ethics, documentation, assessment, evaluation, and prescribing practices for 6 out of the 10 patient records reviewed (See Exhibits D, E, H I, J, and K). The Consultant opined that the Respondent did not meet the community standard of care in the areas of documentation, assessment, evaluation, and prescribing practices for all 10 patient records reviewed (See Exhibits D-M). The Consultant opined that there is a clear pattern of substandard medical care provided by the Respondent that is grossly below the community standard. The Consultant further opined that the Respondent's substandard care has resulted in patient death, serious adverse outcomes, and criminal investigations.

Exhibit Legend:

A. The DCD Report
B. The CMEB Statement on the use of Controlled Substances for the Treatment of Pain
C. Statement from the Respondent (Copies of his office records are located in the Exhibits D-M).
D. Outline for patient A (K.R).
    1. Pharmacy records
    2. Respondent's office notes
    3. Dental records
E. Outline for patient B (T.P).
    1. Pharmacy records
    2. Respondent's office notes
F. Outline for patient C (R.O).
    1. Pharmacy records
    2. Respondent's office notes
G. Outline for patient D (P.B.P).
    1. Pharmacy records
    2. Respondent's office notes
    3. Dental records
H. Outline for patient E (M.D).
    1. Pharmacy records
    2. Respondent's office notes
I. Outline for patient F (D.T.W).
    1. Pharmacy records
    2. Respondent's office notes
    3. PCP office records
J. Outline for patient G (L.W).
    1. Pharmacy records
    2. Respondent's office notes
K. Outline for patient H (K.O.C).
    1. Pharmacy records
    2. Respondent's office notes
L. Outline for patient I (P.B).
    1. Pharmacy records
    2. Respondent's office notes
    3. PCP office records
    4. Surgeon's office records
    5. Orthopedic consult's office records
    6. Police Reports
        a. Police Report received from DCD
    7. Autopsy Report
M. Outline for patient J (S.B).
    1. Pharmacy records
    2. Respondent's office notes
    3. Hebrew Healthcare records
    4. Rocky Hill SNF records
    5. NBGH records
    6. PCP office records
    7. Police records
    8. Police records dated 10/13/2009

9. Autopsy Report

N. Sworn statement from J.B., daughter of patient I (P.B) & patient J (S.B).
O. Sworn statement from J.B., daughter of patient I (P.B) & patient J (S.B).
P. CLIA waiver violation
Q. Police records on D.S.
R. Dr. Power's report
S. The Department's allegation letter and the Respondent's written statement
T. The Consultant's Report

Communication Log:

John Gadea, Jr., Director, Drug Control Division (Petitioner)
Department of Consumer Protection
165 Capitol Avenue, Room 145
Hartford, CT 06106

Gerson M. Sternstein, MD (Respondent) (Written Statement)
Paragon Behavioral Health, L.L.C.
26 Chamberlain Highway
Berlin, CT 06037

Richard Tynan, Esquire (Respondent's Attorney)
Halloran & Sage, L.L.P.
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Hartford, CT 06103

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Director, Controlled Substances/Toxicology Laboratory
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[redacted] (Daughter of PB & SB) (Sworn Statements)

Patrick M. Rocco, MD (PB's Surgeon)
279 New Britain Road, #10
Kensington, CT 06037

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Weatogue, CT 06089

Paul Fitzgerald, Chief of Police
Berlin Police Department
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Michael S. Honor, MD (DTW's PCP)
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Elizabeth Solano, MD (PB's & SB's PCP)
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Frank J. Gerratana, MD (PB's Orthopedic)
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Rocky Hill Skilled Nursing & Rehabilitation Center
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Paul Henry Zottola, DMD (KR's Dentist)
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Suzanne E. Ducate, MD (Consultant)
Department of Correction
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Health & Addictions Services Unit
Wethersfield, CT 06109-1152

STATE OF CONNECTICUT

DEPARTMENT OF CORRECTION
24 WOLCOTT HILL ROAD
WETHERSFIELD, CONNECTICUT 06109

Suzanne Ducate, M.D.
Psychiatric Services

Health & Addiction Services
Phone: 860-692-6262

Rec'd 7/19/10

July 17, 2010

TO: RoseMarie Deschenes, APRN, Nurse Consultant
Department of Public Health, Health Care Systems Branch
Office of Practitioner Licensing and Certification
410 Capitol Avenue, MS #12HSR
P.O. Box 340308
Hartford, CT 06134-0308

RE: Petition No: 2009-0115-001-009/2009-200921

Dear Ms. Deschenes,

I have completed the review and reports you requested on May 9, 2010 for the investigation of the above petition regarding the medical practice of Gerson Sternstein, M.D. In addition to a review of the documents associated with each of the ten cases you submitted for my review, I reviewed the following documents: Three letters with lists of exhibits and comments from you requesting my review dated April 9, 2010, May 19, 2010, and June 30, 2010; Exhibit outlines, a letter from you dated April 5, 2010 that explains my role in the investigation; the Statement of the Connecticut Medical Examining Board on the use of Controlled Substances for the Treatment of Pain; your request for information from Dr. Sternstein regarding the petition dated January 26, 2010; the response of Dr. Sternstein via his attorney, Richard Tynan dated March 23, 2010; a report dated August 17, 2009 from the Department of Consumer Protection; Calloway Laboratories Complaint dated December 9, 2009; a Berlin Police Department report regarding the arrest of a person for selling prescriptions written by Dr. Sternstein, and a review of toxicological findings from four autopsy reports by Robert Powers, PhD, dated February 2, 2010.

The review of additional documents outside of the documents that pertain to the ten cases, support the conclusions in all of the ten cases. The complaint from Calloway laboratories states that a Calloway Laboratories employee was performing urine drug testing on site at Dr. Sternstein's office without a CLIA Certificate, which is against the law. The Berlin Police Department report from August 16, 2006 revealed that a patient of Dr. Sternstein reported to police that another patient of Dr. Sternstein, [redacted] obtained prescriptions from Dr. Sternstein then filled the prescriptions for Percocet and sold the 90 pills for $400.00 to an unknown male named "[redacted]" The report goes on to state that a DCF employee received a complaint that [redacted] was selling drugs out of her house with children present. When [redacted] was interviewed by the police she claimed she gave medication to the male, "[redacted]," but did not sell him the pills. The Berlin police did issue a warrant for [redacted] arrest on September 18, 2006 for illegal sale of narcotics. The report dated August 17, 2009 from the Department of Consumer Protection, Drug Control Division, indicated that Dr. Gerson Sternstein wrote more prescriptions during the time period of 7/6/2008 through 8/6/2009 than all of the Yale New Haven Hospital. In fact, Dr. Sternstein was the number one prescriber by number of prescriptions in the State of Connecticut during that time period. He wrote 2,441,520 doses of medication to 1,496 patients. Yale New Haven wrote 1,759,740 doses of medication to 20,689 patients. All of these documents support the pattern of reckless and possibly illegal behavior of Dr. Sternstein and his patients, as well as the exceedingly large number of narcotics prescriptions he writes that was noted in the review of the individual cases submitted.

The toxicology review dated February 2, 2010 stated that in the case of OCME CN 08-15118, Dr. Powers agreed with the medical examiner's finding of death due to opiate toxicity. The toxicology review supports my findings that potentially lethal doses of opiate medication are prescribed by Dr. Sternstein.

The response of Dr. Sternstein to the concerns of the Department of Public Health in my medical opinion do not adequately address the questions raised. His answers are not supported by a review of the relevant medical literature, Federal and State guidelines, and community practice standards. He does not answer the question about increasing doses of medication without measurable objectives or outcomes. He only replies that the dose of medication is unimportant as long as the patient reports pain relief. Some of his responses also appear to be flippant, for example; when asked about positive urinalysis for illicit substances the response is that Dr. Sternstein distinguishes between "recreational" versus "substance abuse." State and Federal statutes, as well as ethical medical practice, do not allow "recreational" use of illicit substances. Another example of a flippant response by Dr. Sternstein is in response to the question of writing prescriptions for patients who do not fill them. As part of his response the letter states, "Dr. Sternstein is not aware of any mandate for physicians that prescribe scheduled or unscheduled medications to track when and where they are filled." The physician's monitoring of patient medication compliance and potential misuse and abuse of medications is a well-accepted part of a physician's responsibility to his patients. Dr. Sternstein believes Medicare D allows wide latitude in off label use of medications and the mailing of prescriptions to patients one to two weeks ahead of time. Dr. Sternstein also believes that patients should "shop" for medication based upon price and insurance coverage. He also indicated in more than one case that it is not his responsibility to coordinate care with dentists prescribing pain medications or other physicians prescribing controlled substances, which is not the community standard of care.

After a review of all of the documents provided, a review and citation of relevant references, writing the ten case reports for sixty-five hours, and my training and experience as a psychiatrist board certified in general psychiatry, with additional qualifications in addiction and forensic psychiatry, it is my opinion made with a reasonable degree of medical certainty, that there is a clear pattern of substandard medical care provided by Dr. Gerson Sternstein that is grossly below the community standard of care. I recommend an expedited review of the evidence collected in your investigation as the substandard care provided by Dr. Sternstein has resulted in patient death, serious adverse outcomes, and criminal investigations.

Sincerely,

Suzanne Ducate M.D.

Suzanne Ducate, M.D.

rec'd 7/19/10

Consultant Review

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: K[redacted] M. R[redacted] (DOB[redacted])

Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Mr. R[redacted] dated 1/26/06 through 9/3/09, including correspondence from Dr.'s Druckemiller and Becker, Records from Hartford Neurology, and Orthopedic Associates of Hartford; Prescription history and photocopies, including Arrow, Walgreens, Rite Aid, and Beacon prescription records; and Dental Records from Zottola Periodontal Group dated 1/24/08 through6/1/2009. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
K[redacted] R[redacted], DOB[redacted], received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 1/26/06 for a chief complaint of anger issues he related to interferon treatment for Hepatitis C and "no one is giving me pain medicine." He was found to have depression, anxiety, hepatitis C, head injury with short-term memory problems, cervical neck pain, and right knee pain. He was noted to have abused alcohol and cocaine with at least two detoxification admissions and a DUI conviction. He was noted to have treatment for depression and anxiety with Effexor XR and Xanax but complained that he had no pain medication, and he stated, "I need some." The plan after the initial evaluation was individual therapy, pain group, and medication evaluation and monitoring.

All of the following notations from Dr. Sternstein's medical records that were reviewed are brief and labeled medication evaluation requests with a heading of Degenerative Neck Disc Disease or no problem heading and appeared to be completed by more than one clinician. If a clinician other than Dr. Sternstein makes the notations he appears to co-sign the note. The practice of co-signing another practitioner's notes and prescribing controlled substances without evaluation of the patient by the prescriber is not the community standard of care.

All of the documentation on these notations that date from 11/20/06 through 6/23/09 are composed of the patient's report of symptoms, social/work history, and the patient's explanation of treatment by other providers. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the

patient's functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail.

Occasionally references to completed urine toxicology are made but the results are not connected to the treatment referenced. Notation is made of MRI scans completed and consultations to Neurology and Orthopedics but the results of these are not connected to the treatment referenced in the medical record notations. All of the notations are barely legible and extremely brief.

There are several MRI reports from Dr. Becker addressed to Dr. Sternstein and letters addressed to Dr. Sternstein from Dr. Druckemiller, who treated Mr. R[redacted] for his neck pain with a combination of traction and surgery. There is also a report from Hartford Neurology and Orthopedic Associates of Hartford. These reports and letters are dated from 6/8/2006 through 5/18/2009. The first MRI reports from June of 2006 reveal mild disc degeneration and foraminal stenosis. Dr. Druckemiller recommends a course of traction followed by another evaluation. This plan is formulated after a physical exam and a review of the MRI.

The next letter from Dr. Druckemiller in July of 2006 indicates he is considering surgery to treat continued symptoms and restricted movement of the patient's neck. In August of 2006 Dr. Druckemiller recommends anterior cervical fusion surgery. On October 30, 2006, Dr. Druckemiller saw the patient for follow up after surgery and writes that he is doing well. On December 11, 2006 Dr. Druckemiller saw Mr. R[redacted] to follow up his surgery. He writes that the patient is doing well and has good relief of pain. X-rays showed good, early fusion. He prescribes physical therapy and follow-up with radiology. Again in January, February, and March of 2007, Dr. Druckemiller states Mr. R[redacted] is improving each month and by March is doing quite well, has no significant neck complaints and may return to work. Dr. Sternstein's records from November of 2006 through March of 2007 indicate treatment with perocet and oxycodone in November. Dr. Sternstein indicates that he intends to taper the Percocet and use oxycodone. Dr. Druckemiller reports that Mr. R[redacted] indicates no significant neck complaints by March of 2007 and Dr. Sternstein's record indicates that Mr. R[redacted] is in the midst of domestic problems, has a restraining order against him, but does show symptomatic improvement. The use of Suboxone is discussed to wean him off of pain medication in March of 2007. The care provided by Dr. Sternstein is below community standard because the surgeon treating Mr. R[redacted] clearly reports improvement of pain and physical function secondary traction and surgery. The other physician does not document an objective need for opiate medication treatment in this case. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. It is below community standard to prescribe large doses of opiate medication without objective evidence of their necessity.

In April of 2007, Mr. R[redacted] begins reporting increased pain in his neck and back while on light duty at work. In May of 2007 he continues to complain of

"knotting" in neck and the plan is to continue the present regimen. In June of 2007 the record indicates Mr. R[redacted] is prescribed Provigil (a stimulant) to increase alertness during night shift work. In August, Dr. Sternstein's records note that the patient now complains of knee pain and Oxycodone, (an opiate agonist that produces sedation), 4 tablets four times per day is the assessment and plan. It is not the community standard of care to prescribe multiple different controlled substances to any patient, especially one with a documented history of drug addiction.

August of 2007 is the first date that Dr. Sternstein's prescription log begins and it runs through July 2009. The log indicates that in August of 2007, Mr. R[redacted] was prescribed three prescriptions of Oxycodone, 30mg tablets, to be taken three tablets every four hours as needed. If Mr. R[redacted] took all of the medication prescribed, he would ingest 540 mg of Oxycodone per day. (The morphine equivalent would be 270mg per day, which exceeds the absolute maximum of 180 mg of morphine equivalent per day in the literature.) Similar prescriptions were written for September of 2007 and October 2007 with the addition of the Provigil twice per day. Through the remainder of 2007, Mr. R[redacted] is prescribed Oxycodone, Vicoden, and Provigil, according to Dr. Sternstein's log. From August 2007-December 2007, Mr. R[redacted] is prescribed 360 tablets of 30mg Oxycodone in August, the same amount in September, 480 tablets of 30mg Oxycodone with 60 tablets of 200mg Provigil with two refills in October, 480 tablets of 30mg Oxycodone, with 15 tablets of 40mg Oxycontin in November, and 480 tablets of 30mg Oxycodone, 240 tablets of 15 mg Oxycodone, and 20 tablets of Vicoden ES. Dr. Sternstein's records during this time frame indicate that the patient is stable from August until October of 2007 when he notes the patient is angry at being told he needs a medication taper. In December, it is documented that the patient is having difficulty managing his father's estate so the plan is to increase his medication dose to treat "break-though and tolerance." The medication log only indicates an increase in prescriptions rather than any decrease or taper. It is below the community standard of care to prescribe potentially lethal doses of medication to a patient with drug addiction, a history of depression and anxiety, and current psychosocial stresses without documenting risk of patient suicide or informing the patient of the risks of the medications prescribed.

In January 2008, Dr. Sternstein indicates he would like to use Suboxone (a mixed opioid agonist/antagonist) to wean the patient off of opioids. On January 23, 2008 the patient complains of side effects to Suboxone including dizziness. The note indicates that Oxycodone is added. The prescription log again indicates increasing doses and numbers of medication prescribed throughout January. The patient receives prescriptions for Oxycodone at 30 and 15mg doses, Suboxone at the 8mg dosage, Amrix (a muscle relaxant) at 30mg, and Skelaxin (a muscle relaxant) at 800mg doses. In February 2008, he is prescribed 480 Oxycodone 30mg tablets, 45 Oxycodone 15mg tablets, and Provigil 200mg tablets with refills. It is not standard of care to prescribe opiates with Suboxone, as drug interactions are a risk as well as lowering of effectiveness of both drugs.

In February and March of 2008, Mr. R[redacted] complains of additional pain due to dental procedures and Dr. Sternstein prescribes increased doses of pain

medication. After the dental pain has resolved he continues with the higher doses of medication despite documentation that he intends to decrease the dose. The explanation in the records is that the patient attended a boater's class. There is no communication with the dentist noted. The prescription of controlled substances by a physician for pain due to a dental procedure when the patient is under the care of a dentist is below the community standard of care.

In June of 2008 it is noted that Mr. R[redacted] is being prescribed Xanax by another physician. No coordination of care is apparent. In July of 2008 the patient is given an extra supply of medication for a vacation despite the patient's report that he has reinjured his back and has had another increase in medication. Mr. R[redacted] returns from vacation and now reports increased shoulder pain from use of a fishing boat. Throughout the remainder of 2008 and up until the prescription log ends on July 9, 2009, Dr. Sternstein prescribes higher and higher doses of Oxycodone and adds other medications. These increases are the result of patient report of additional accidents and report of increasing symptoms. There are no objective or even structured subjective evaluations of physical limitation or assessments of the response of the patient's reported pain to treatment. In June of 2009, Mr. R[redacted] was prescribed 260 tablets of Oxycodone 15 mg, 870 tablets of Oxycodone 30mg, 90 tablets of Lyrica (a medication prescribed for fibromyalgia) 50mg, and 30 tablets of Lyrica 75mg. The total amount of Oxycodone prescribed in the month of June 2009 is 30,000mg for a daily average dose of 1,000mg per day. This is in contrast to the 540mg of Oxycodone the patient was prescribed in the fall of 2007. Dr. Sternstein's records regarding Mr. R[redacted] clearly demonstrate an excessive number and strength of scheduled II controlled substances as noted in the complaint. The amount of scheduled II controlled substances prescribed by Dr. Sternstein exceeds the community standard. The prescription of multiple controlled substances is below the community standard of care.

Mr. R[redacted] uses multiple pharmacies, more than one doctor for prescriptions, and pays with both cash and insurance. He has Dr. Sternstein call in prescriptions for more Oxycodone before and after office visits, has urine toxicology screens positive for both methadone and morphine not prescribed by Dr. Sternstein, and has new prescriptions written before the older prescription are expired. Mr. R[redacted] fills benzodiazapine, Lexapro, and Chantix prescriptions written by another physician, has benzodiazapine prescription written by a physician assistant, and he uses both insurance and cash to pay for the prescriptions. In addition, pharmacy records indicate there were prescriptions presented to the pharmacy that were not filled, as well as prescriptions filled that were not identified in the medial record. All of these behaviors indicate both possible misuse and diversion of prescriptions for criminal purposes. A responsible practitioner would at least consider that the patient was diverting or misusing some of this medication. The practice of prescribing massive doses of Schedule II controlled substances, as well as other sedating and activating medication is well below the community standard of care.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. The practice of co-signing another practitioner's notes and prescribing

controlled substances without evaluation of the patient by the prescriber is not the community standard of care. The surgeon treating Mr. R[redacted] clearly reports improvement of pain and physical function secondary to traction and surgery. The other physician does not document an objective need for opiate medication treatment in this case. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. The patient receives prescriptions for Oxycodone at 30 and 15mg doses, Suboxone at the 8mg dosage, Amrix at 30mg, and Skelaxin and 800mg doses. In February 2008, he is prescribed 480 Oxycodone 30mg tablets, 45 Oxycodone 15mg tablets, and Provigil 200mg tablets with refills. It is not standard of care to prescribe opiates with Suboxone, as drug interactions are a risk as well as the lowering of effectiveness of both drugs. Dr. Sternstein prescribed multiple different controlled substances to a patient with a documented history of drug and alcohol addiction. It is below the community standard of care to prescribe potentially lethal doses of medication to a patient with drug addiction, a history of depression and anxiety, and current psychosocial stresses without documenting the risk of patient suicide.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. Dr. Sternstein co-signs the clinical notes of other practitioners and prescribes medication based upon these visits without completing his own documented evaluation on numerous occasions. The community standard of care is to coordinate care within a clinic, for instance, one practitioner conducts psychotherapy or testing and the physician conducts the management of medication. Both practitioners would write their own clinic note demonstrating that both individually evaluated the patient and conducted the care appropriate to their discipline. The different disciplines would then confer to devise a complete plan of care. This does not mean the non-physician evaluates the patient and the physician then writes a prescription without seeing the patient or writing his own clinic note, which is the practice that Dr Sternstein appears to conduct. This is a moderate deviation from the standard of care, as he does not conduct every clinic visit in this fashion and it is not possible to be sure from the records provided that Dr. Sternstein was not at least physically present during these evaluations, even though he did not write his own clinic note. "In New York State the practice of permitting, aiding, or abetting an unlicensed person to perform activities requiring a license is professional misconduct." Chapter 58, Ethics in Psychiatry, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.
2. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms

reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

3. The patient describes domestic problems leading to restraining order and difficulty with an ill parent. He is prescribed potentially lethal doses of opiates and is not assessed for suicide risk. It is the standard of care in the community to assess a patient's risk for suicide when he presents with multiple risk factors, as Mr. R[redacted] did. This is a severe deviation from the standard of care as the potential for a lethal outcome is high. Chapter 34, Emergency Psychiatric Medicine, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003.
4. Despite having information available from specialists and objective tests, such as MRI and urine toxicology, the information is not used to guide the treatment. It is unclear whether there is communication from Dr. Sternstein to the other physicians participating in Mr. R[redacted] care. It is the community standard of care to communicate with other physicians involved in the care, particularly when the treatment the physician is providing is directly related to the condition the other physician is treating. It is important to avoid duplication of treatment, potential negative drug interactions, or care that may disrupt other treatment the patient is receiving. This is a moderate deviation from the standard of care, as other physicians in the community may not always take the time to communicate with their colleagues. However in Mr. R[redacted]'s case the lack of communication poses a greater risk than average due to the high doses of opioid medication being prescribed by Dr. Sternstein and the risk of

respiratory depression and death if he takes too much Oxycodone or there are significant drug interactions with the multiple prescriptions he received. When a patient undergoes surgery, it is imperative for the surgeon to know what medications or substances the patient is using to avoid surgical complications. Chapter 15, Preoperative Medical Evaluation, Goldman, Kelley's Textbook of Internal Medicine, Second Edition, J.B. Lippincott Company, 1992.

5. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Mr. R[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn him of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Mr. R[redacted]s increasing dependence on the Oxycodone over the two year period reviewed. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
6. Pain medication is prescribed according to Dr. Sternstein's records to treat pain secondary to a dental procedure. There is no evidence that this treatment was coordinated with the dentist or that the dentist requested consultation from Dr. Sternstein for pain management. In fact, the dental records from Zottola Periodontal group indicate the dentist's finding on 2/26/08, that higher amounts of medication for pain could be toxic. The community standard is to coordinate care with the dentist if both the physician and the dentist may be prescribing controlled substances. This is a severe deviation of the standard of care due to the high risk of additive opiate toxicity and the dentist's documented concern of lethal toxicity.
7. Dr. Sternstein is aware the patient has a history of drug and alcohol addiction and prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating the patient is also using other opiates that are not prescribed, methadone and morphine, does not alter his plan of care. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction. It is the standard of care to ensure the patient is not misusing the medication or engaging in criminal behavior. This is a severe deviation

from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to this patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov

8. Dr. Sternstein prescribes excessively high doses of Oxycodone. He continues to increase the dose of Oxycodone without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time for acute injuries, especially after the patient has had a positive response to definitive treatment like surgery to correct the injury. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours." (This 90mg per day is in stark contrast to the 1000mg per day Mr. Rabbett is prescribed.) Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Reviews Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain,"Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :
Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5
U.S. Food and Drug Administration, www.FDA.gov, 2010.

9. Dr. Sternstein prescribes Suboxone (a mixed agonist-antagonist opiate) to this patient who is dependent on opiate agonists. It is not standard of care to prescribe opiates with Suboxone, as drug interactions are a risk as well as the lowering of effectiveness of both drugs. In addition, serious withdrawal symptoms can emerge as well as increased risk of opiate abuse. "While taking opioid pain medication, the administration of Buprenorphine should be discontinued." Chapter 2, Pharmacology, and Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.

rec'd 7/19/10

Consultant Review

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: T[redacted] P[redacted] DOB: [redacted]

Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Dr. Sternstein's records dated 8/21/08 through 6/8/2009. Records from Dr. Schecter dated 12/1/2008 through 3/11/2009, a radiology report dated 1/24/06, a letter from Dr. Sternstein to Probation Officer Wexler dated 4/27/09, prescription history and photocopies, including Beacon, Rite Aid, CVS, and Walgreens. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:

T[redacted] P[redacted] received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 8/21/2008 for a chief complaint of needing Suboxone for opiate dependence and "pain prevents me from moving around on my job." The clinician wrote that, "patient attempting to emphasize chronic pain, though no clear diagnosis." He had a history of polysubstance abuse and treatment with prescription opiate medication. He is found to have Opioid Dependence and the patient states that he wishes to have "less expensive suboxone than the cash only system of Dr. L." It was noted that Mr. P[redacted] would continue to receive supplemental pain medication from his primary care provider.

Most patients should stabilize on Suboxone daily doses of 16/4-24/6. Mr. P[redacted] from the beginning of his treatment with Dr. Sternstein is instead prescribed what is considered a maximum dose of 32/8. Knowingly prescribing Suboxone while another provider prescribes opioid medication for pain falls below the community standard of care. The doses of Suboxone prescribed by Dr. Sternstein are in excess of accepted practice.

In addition, the patient's report that he is looking for a cheaper Suboxone should be a red flag for possible misuse and abuse of the drug by the patient. This possibility is never addressed by Dr. Sternstein. He never indicates that he has any knowledge that the patient uses multiple pharmacies, multiple physicians for schedule II medications and he does not address the urine toxicology screens that are positive for narcotics not prescribed by him. He is aware the patient is on Probation but does not carefully monitor these dangerous practices of his patient. He only continues to prescribe a variety of medications that are well known to cause

serious substance dependence. These practices are well below the community standard of care and put the practitioner at risk for criminal prosecution.

The clinic notes during this time period indicate that the patient stated the Suboxone helped cravings but that it "amps him up," and asks for Ativan. He also claims dental problems that he refers to over the next five visits. The prescription of controlled substances by a physician for pain due to a dental procedure when the patient is under the care of a dentist is not the community standard of care.

On 11/19/2008 Mr. P[redacted] claims to have "panic attacks." The Lorazepam prescription is presumably for "panic attacks," although there is no investigation into this patient report and it is clear the patient had been seeking this medication for several visits prior. On November 19, 2008 Mr. P[redacted] received Lorazepam, 1mg, 30 tablets and again the same prescription on 12/16/2008 and on 1/14/2009, less than 30 and 60 days later. The use of sedative-hypnotics like the benzodiazepine, lorazepam, with Suboxone and Opiates is contraindicated due to risk of death. This practice falls below the community standard of care. In addition, Dr. Sternstein's prescriptions are almost always written before the last one had expired, ensuring the patient always had more pills than indicated.

On 12/3/08, the patient reports a visit to the ER for an ankle injury and admits to being prescribed Vicoden. On 2/11/09 the patient admits he is using increased Suboxone for back pain. For the remainder of February and early March it is noted the patient is receiving opioid medication from other physicians. Beginning on 3/18/2009, Dr. Sternstein's notes reflect what the PMP reports and is verified by a letter from Dr. Schecter dated March 11, 2009, that Dr. Sternstein is now to provide for the patient's "pain management" in addition to treating his opiate "addiction." This documentation is consistent with the following prescriptions Dr. Sternstein writes for Mr. P[redacted] to include prescriptions for Endocet, Oxycontin, and Lyrica. He also continues to prescribe lorazepam. There are no objective or even structured subjective evaluations of physical limitation or assessments of the response of the patient's reported pain to treatment. These prescriptions reflect a substandard level of care due to the prescription of Suboxone in combination with opioid medications, as well as the prescription of Schedule II narcotics without a clear indication and in response to patient request rather than clinical rationale.

An example of Dr. Sternstein's prescription practices of opioid and other medications are the prescriptions he wrote for Mr. P[redacted] in July 2009. Dr. Sternstein prescribed Endocet 325/10 mg tablets, #300 Oxycodone with acetaminophen; (This would be equal to 300 mg of Oxycodone per day. The equivalent dose of morphine would be 150mg per day) for the month, Lyrica 75 mg capsules, #90 for the month, Oxycontin, 80 mg controlled release tablets, #90 (This would be equal to 240 mg per day. The equivalent dose of morphine would be 120 mg per day) for the month, and Suboxone 8.64/2.44mg tablets, #120 for the month. These prescriptions are exceedingly high doses of medication and prescribed in combination. This practice is below the community standard of care.

In addition, most clinic notes in Dr. Sternstein's records appear to be completed by more than one clinician. If the notations are made by a clinician other than Dr. Sternstein, he appears to co-sign the note. The practice of co-signing

another practitioner's notes and prescribing controlled substances without evaluation of the patient by the prescriber is not the community standard of care.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. The practice of co-signing another practitioners note and prescribing controlled substances without evaluation of the patient by the prescriber is not the community standard of care. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. Dr. Sternstein prescribed multiple different controlled substances to a patient with a documented history of drug addiction. Pharmacy records indicate that Mr. P[redacted] presented prescriptions to the pharmacy that were not filled and other prescriptions that were filled were not documented in the medical record.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. Dr. Sternstein co-signs the clinical notes of other practitioners and prescribes medication based upon these visits without completing his own documented evaluation on numerous occasions. The community standard of care is to coordinate care within a clinic, for instance, one practitioner conducts psychotherapy or testing and the physician conducts the management of medication. Both practitioners would write their own clinic note demonstrating that both individually evaluated the patient and conducted the care appropriate to their discipline. The different disciplines would then confer to devise a complete plan of care. This does not mean the non-physician evaluates the patient and the physician then writes a prescription without seeing the patient or writing his own clinic note, which is the practice that Dr Sternstein appears to conduct. This is a moderate deviation from the standard of care, as he does not conduct every clinic visit in this fashion and it is not possible to be sure from the records provided that Dr. Sternstein was not at least physically present during these evaluations, even though he did not write his own clinic note. "In New York State the practice of permitting, aiding, or abetting an unlicensed person to perform activities requiring a license is professional misconduct." Chapter 58, Ethics in Psychiatry, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.
2. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is

clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

3. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Mr. P[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn him of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Mr. P[redacted] increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
4. Pain medication is prescribed according to Dr. Sternstein's records to treat pain secondary to dental procedures. There is no evidence that this treatment was coordinated with the dentist or that the dentist requested consultation from Dr. Sternstein for pain management. The community

standard is to coordinate care with the dentist if both the physician and the dentist may be prescribing controlled substances. This is a severe deviation of the standard of care due to the high risk of additive opiate toxicity.

5. Dr. Sternstein is aware the patient has a history of drug and alcohol addiction and prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating the patient is also using other opiates that are not prescribed by Dr. Sternstein. Dr. Sternstein was aware the patient was on probation. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior. It is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal conduct. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to this patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov
6. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and Suboxone without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com,

2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010. (Mr. Paradis is prescribed the morphine equivalent of 270mg per day of Oxycodone by Dr. Sternstein.)

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.

7. Dr. Sternstein prescribes Suboxone (a mixed agonist-antagonist opiate) to this patient who is dependent on opiate agonists. It is not standard of care to prescribe opiates with Suboxone as drug interactions are a risk as well as the lowering of effectiveness of both drugs. In addition, serious withdrawal symptoms can emerge as well as increased risk of opiate abuse. Chapter 2, Pharmacology, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
8. Dr. Sternstein prescribes Lorazepam (a benzodiazepine) for unclear and undocumented indications in combination with opioid medications and Suboxone. "The use of sedative-hypnotics (benzodiazepines, barbiturates, and others) is a relative contraindication to treatment with buprenorphine because the combination (especially in overdose) has been reported to be associated with deaths." Chapter 2, Pharmacology, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
9. Dr. Sternstein prescribes maximum doses of Suboxone without any objective evidence for the maximum doses. He does not use objective measures to document the need for the medication and began treatment with the maximum dose of Suboxone. It is not standard of care to prescribe opiates

with Suboxone, as drug interactions are a risk as well as the lowering of effectiveness of both drugs. In addition, serious withdrawal symptoms can emerge as well as increased risk of opiate abuse. "While taking opioid pain medication, the administration of Buprenorphine should be discontinued." Chapter 2, Pharmacology, and Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.

rec'd 7/19/10

Consultant Review

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: R[redacted] O[redacted] (DOB[redacted])

Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Mr. O[redacted] dated 1/10/07 through 5/21/2009, Records from Dr. Becker dated from 7/22/1991 through4/18/1998. I have reviewed prescription history and photocopies from Walgreens, Wal-Mart, and Beacon pharmacies. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
R[redacted] O[redacted] DOB[redacted], received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 7/19/07 for a chief complaint of "I want to function and work again." He complained of back and neck pain. He is found to have Major Depression and Pain Disorder with Psychological Factors. The evaluator wrote that the patient only endorsed the use of beer or wine on occasion, and no other substance use. Later in the evaluation he did report use of multiple prescription medications including Valium, Soma, Tylox, Flexeril, Talwin, Vicoden, and Perocet. Mr. O[redacted] stated he had been in care of Dr. Becker for spinal surgery on his lower back after a fall and had increased neck and back pain since 1996 due to a motor vehicle accident. Dr. Becker had prescribed physical therapy in the past. In the conclusion, the interviewer noted that the patient had been using Percocet not prescribed to him. He was also described as having a "low mood." He was referred for pain group and medication evaluation and monitoring.

However, Dr. Sternstein's prescription log, beginning 1/10/2007, indicates there were prescriptions written by Dr. Sternstein for Mr. O[redacted] prior to the document dated 7/19/07 with the heading Paragon Behavioral Health Initial Evaluation. The prescription log indicates that Dr. Sternstein was prescribing Oxycontin, Percocet, SOMA, and Serzone prior to the Initial Evaluation in the records reviewed. The first clinic note in the records is dated 2/8/2007 and is typed and is also prior to the "Initial Evaluation." Records provided by Wal-Mart and Beacon pharmacies, indicate that Mr. O[redacted] paid for many of his prescriptions with cash, used multiple pharmacy chains in different towns, and there were duplicate prescriptions written one or two days apart. Mr. O[redacted] paid thousands of dollars for prescriptions written by Dr. Sternstein. There were prescriptions written that

do not appear to have been filled. Dr. Sternstein's prescription log indicates that prescriptions written for Mr. O[redacted] in February 2008 were for Oxycontin 40mg, 140 tablets, Oxycontin 40mg, 140 tablets, Percocet 5/325mg, 360 tablets, Oxycontin 40 mg, 170 tablets, and Percocet 5/325mg, 360 tablets. At this same time, Mr. O[redacted]s urine toxicology was positive for methadone, which was not prescribed by Dr. Sternstein. There is a continued pattern displayed by Mr. O[redacted] throughout 2008 of multiple prescriptions for Schedule II medications prescribed for vague reasons, thousands of dollars spent by the patient for medications, and multiple prescriptions written without being filled, that indicate possible criminal activity. These behaviors are indicative of possible misuse and/or diversion of the Controlled Substance prescriptions written by Dr. Sternstein for Mr. O[redacted] for criminal purposes. On 1/26/2009 Mr. O[redacted] is arrested. These practices are well below the community standard of care and put the practitioner at risk for criminal prosecution. It is below the community standard of care to prescribe controlled substances to a patient who is demonstrating misuse or diversion of the medications.

The typed clinic notes in Dr. Sternstein's records from 2/8/2007 through 12/24/2007 indicate a "stable" patient being seen every two months by Dr. Sternstein with documentation that solely reports the patient's view of his symptoms and social/work history. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail.

The prescription log provided by Dr. Sternstein indicates that during this time period Mr. O[redacted] is given prescriptions on many dates when he has not been seen by Dr. Sternstein. For example during the month of May 2007 there are no clinic notes from Dr. Sternstein, however the prescription log indicates that Mr. O[redacted] was prescribed Oxycontin 40mg, 267 tablets and Percocet, 5/325 mg, 360 tablets without being seen by the doctor. It is below the community standard of care to prescribe large amounts of Schedule II controlled substances without examining the patient.

The clinic notes from 2008 and 2009 are consistent with the notes from 2007, lacking detail and without objective evidence of a need for the high doses of Schedule II medications prescribed for Mr. O[redacted] by Dr. Sternstein. In early 2008, the patient alters his medication regimen on his own and Dr. Sternstein notes that he is concerned about the high doses of Percocet the patient is using due to toxicity. However, Dr. Sternstein takes no definitive action to address his concern. In June of 2008, Dr. Sternstein adds another medication, Ambien (a benzodiazepine-like medication for sleep) due to psychosocial complaints. In December of 2008 Mr. O[redacted] reports that he had an accident while moving a refrigerator and admits to increasing the use of medication on his own again. Dr. Sternstein does not verify the

injury, instead he increases the dose of opiate medication without any objective reason to do so and despite the patient's admission that he has not been taking the medication as prescribed. In January of 2009, Mr. O[redacted] reveals that he has been arrested and that he uses multiple pharmacies in order to obtain more medication. Dr. Sternstein documents that Mr. O[redacted] has difficulty maintaining medication discipline but only prescribes more medication due to patient report of increased pain without objective evidence. There are no objective or even structured subjective evaluations of physical limitation or assessments of the response of the patient's reported pain to treatment. These prescriptions reflect a substandard level of care due to the prescription of Schedule II narcotics without clear indication and in response to patient request rather than clinical rationale.

In addition, these prescriptions are for exceedingly high doses of medication and prescribed in combination. Dr. Sternstein's prescription log indicates that in February 2007, Mr. O[redacted] is prescribed Oxycontin 40mg, 240 tablets and Percocet 5/325 mg, 360 tablets. By January of 2009, Mr. O[redacted] is prescribed Oxycontin 40mg, 120 tablets, Oxycontin 80mg, 480 tablets, Percocet 5/325mg, 720 tablets, SOMA 120 tablets, and Serzone 50mg, 60 tablets. Over a period of approximately two years, a patient who is known to abuse controlled substances is prescribed an increase of Schedule II narcotics by Dr. Sternstein that is quite dramatic. The total mg of Oxycontin is increased from 9,600mg to 43,200mg per month. The total mg of Percocet is increased from 1800/117,000mg to 3600/234,000mg. Dr. Sternstein also added SOMA (another narcotic) and Serzone (an antidepressant). This practice is well below the community standard of care.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. Dr. Sternstein casually prescribed high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. Dr. Sternstein prescribed multiple different controlled substances to a patient who lacks objective evidence of need for the prescriptions and who also appears to misuse or divert many of the prescriptions.

Summary of Findings:

The documents reviewed indicate the practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the

diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

2. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Mr. O[redacted] and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn him of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Mr. O[redacted]s increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
3. Dr. Sternstein is aware the patient has a history of drug and alcohol addiction and prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating the patient is also using other opiates that are not prescribed by Dr. Sternstein. Dr. Sternstein was aware the patient had trouble with the law. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior. It is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal conduct. This is a severe deviation from the

standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to this patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov.

4. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and antidepressants without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Reviews Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain,"Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.

Consultant Review

rec'd 7/19/10

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D.

Petition No: 2009-0115-001-009
2009-200921

Petitioner: P[redacted] P[redacted] (DOB: [redacted])

Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Ms. P[redacted] dated 2/14/02 through 9/9/2009, Letters from Orthopedic Associates of Hartford dated 8/15/2001 through 9/6/2001, a letter from Neurosurgeons of Central Connecticut dated 7/22/2004, Dental records from Dr. Schulman dated from 6/16/2008 through 1/27/2009. Prescription history and photocopies, including Rite Aid, Osco, Walgreens, Beacon, Stop and Shop, and Suburban pharmacies. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
P[redacted] P[redacted] DOB [redacted] received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 2/14/2002 for a chief complaint of addiction and she requested Naltrexone. She reported a history of detoxification admissions for heroin dependence and used heroin the day of her appointment. She also admitted to using cocaine, crack, and prescription opioids. She is found to have Opiate Dependence, cervical disc disease, and traumatic injury to her arm. The record resumes on 10/18/2006 with barely legible clinic notes dated through 6/10/09, composed of patient report of symptoms, social/work history, and the patient's explanation of treatment by other providers. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail.

The letters from Orthopedic Associates of Hartford beginning in August of 2001 indicate that Ms. P[redacted] was seen to assess complaints of back and shoulder pain due to a car accident in 1993. The examination did not reveal significant pathology and exercise and physical therapy are recommended. Only a short course of narcotic at night was recommended. Approximately two weeks later Ms. [redacted]

is seen by the Orthopedic service complaining of a recent motor vehicle accident. She was referred for MRI. The MRI was reviewed by the Orthopedic specialist on 9/6/2001, there were no definite compressions of the neural structures and physical therapy was recommended. The letter from Neurosurgeons of Central Connecticut, dated 7/22/2004 indicates that Ms. P[redacted] was being evaluated for yet another motor vehicle accident in December of 2003. An MRI done 6/3/2004 was reviewed and there were no significant findings requiring surgical intervention. She was found on physical examination to have symptoms most consistent with cervical strain. She was advised that the recommended treatment was trigger point injections and over the counter Aleve. Thus, the specialist recommendations based upon objective assessments did not support the use of large doses of opiate medication over a long period of time. It is not the community standard of care to prescribe large doses of opiate medication to treat non-specific pain that has been demonstrated by specialist consultation and objective testing to require interventions such as physical therapy rather than the use of controlled substances.

In June of 2008 and January of 2009, Ms. P[redacted] complained of additional pain due to dental procedures and Dr. Sternstein prescribed increased doses of pain medication. After the dental pain had resolved, he continues with the higher doses of medication. There is no communication with the dentist noted. The prescription of controlled substances by a physician for pain due to a dental procedure, without communicating with the dentist, who may be prescribing medication for pain as well, is not the community standard of care.

In addition, the patient's report of a long history of drug abuse with multiple urine toxicology reports positive for cocaine throughout the time period of the records reviewed, urine toxicology reports that are inconclusive due to diluted specimens, and a conviction for assault and paraphernalia should arouse suspicion of medication misuse. Also, the use of a large amount of cash and insurance to pay for prescriptions and the use of multiple pharmacies in different towns, are all indications that Ms. P[redacted] was possibly misusing and abusing the prescribed medications. This possibility was never addressed by Dr. Sternstein. In fact, there are letters included in the records written by Dr. Sternstein that despite evidence of medication misuse, he believes Ms. P[redacted] is using the prescriptions appropriately. He only continues to prescribe a variety of medications that are well known to cause serious substance dependence without clinical justification for their use. These practices are well below the community standard of care and put the practitioner at risk for criminal prosecution.

An example of Dr. Sternstein's inappropriate prescribing of opioid and other medications that are indicative of the pattern of prescribing he engages in throughout the record, are the prescriptions he wrote for Ms. P[redacted] during the month of June 2009. Dr. Sternstein prescribed Methadone (a long acting opiate) 10 mg, #700 for the month, Oxycontin (opiate) 80 mg , #150 for the month, Roxycodone (opiate) 30mg, #900 for the month, Xanax (benzodiazepine) 1mg, #225 for the month, a Lamictal (anticonvulsant) starter pack, and Provigil (amphetamine like stimulant) 200mg, #60 for the month. The ICD-9 codes used for the Provigil prescriptions vary and Provigil was not filled secondary to insurance not covering the prescription due to an incorrect ICD-9 code. These prescriptions

are exceedingly high doses of medication and prescribed in combination. There are no clear indications in the record for the medications prescribed. The doses prescribed are so large that that death could occur from respiratory depression and coma. A reasonable practitioner would at least consider that the patient was diverting or misusing some of the medication. The practice of prescribing massive doses of Schedule II controlled substances, in combination with other sedating and activating medication is well below the community standard of care.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. Dr. Sternstein prescribes medication for dental pain without communicating with the dentist. Dr. Sternstein prescribes extremely high doses of multiple different controlled substances to a patient with a documented history of drug addiction.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates

Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

2. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Ms. P[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn her of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Ms. P[redacted]'s increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
3. Pain medication is prescribed according to Dr. Sternstein's records to treat pain secondary to dental procedures. There is no evidence that this treatment was coordinated with the dentist or that the dentist requested consultation from Dr. Sternstein for pain management. The community standard is to coordinate care with the dentist if both the physician and the dentist may be prescribing controlled substances. This is a severe deviation of the standard of care due to the high risk of additive opiate toxicity.
4. Dr. Sternstein is aware the patient has a history of drug and alcohol addiction and prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating that Ms. P[redacted] is also using cocaine. Dr. Sternstein was aware the patient has a significant history of drug abuse and dependence. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior. It is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal conduct. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to this patient. "State laws governing the prescription of opiods to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the

use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov

5. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and other addictive medications without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5

Morphine 0.5
U.S. Food and Drug Administration, www.FDA.gov, 2010.

rec'd 7/9/10

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: M[redacted] D[redacted] (DOB: [redacted])

Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Mr. D[redacted] dated 1/30/02 through 9/16/2009, Records from Hartford Hospital Department of Rehabilitation, Outpatient Physiatry dated from 12/26/2001 through 9/17/2001. Letters regarding legal issues to and from Dr. Sternstein's office dated 3/14/2002 through 2/2/2005. State police reports dated 1/13/09 and 3/23/09. Prescription history and photocopies, including Walgreens, Durham, Rite Aid, Wal-Mart, and CVS pharmacies. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
M[redacted] D[redacted], DOB[redacted] received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 1/30/2002 for a chief complaint of depression and arm and neck pain. He had a history of polysubstance abuse and treatment with prescription opiate medication. He was found to have pain and depression. Prior to this evaluation by Paragon Behavioral Health, Mr. D[redacted] was followed by the Hartford Hospital Department of Rehabilitation during the first half of 2001. Mr. D[redacted] was referred to Dr. Sternstein after the treatment provided by Dr. Monti did not result in subjective pain relief for Mr. D[redacted], leading Dr. Monti to seek a second opinion from Dr. Kost. The need for a second opinion from a pain specialist, who could do more invasive procedures, came from the fact that despite prescription of reasonable doses of opiate medications and prescribed exercise the patient reported continued pain. During Dr. Monti's physical examination the patient was in no acute distress, he had normal strength in his upper extremities, and his neurologic examination was normal on 9/17/01, but the patient's subjective distress was not improving. The patient provided Dr. Monti with the name of Dr. Sternstein as another possible consultant, a psychiatrist who, according to the patient, also did pain management. It appears the patient chose to see Dr. Sternstein for another opinion.

The clinic notes from Dr. Sternstein's records dated from 2006-2009 are all brief and labeled medication evaluation requests. Most of the notes appear to be completed by a clinician other than Dr. Sternstein, but sometimes cosigned by Dr. Sternstein. The practice of co-signing another practitioner's notes and prescribing

controlled substances without evaluation of the patient by the prescriber is not the community standard of care.

All of the documentation on these notations are primarily composed of patient report of symptoms, social/work history, and the patient's explanation of his psychosocial and occupational stresses. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the patient's functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail.

Mr. D[redacted]used multiple pharmacy chains in different towns, and there were prescriptions written that were not filled in the search of pharmacy records and the prescriptions were provided for vague reasons. His urine toxicology screens also indicated both positive results for illicit drugs such as cocaine and marijuana, but many were negative for the prescribed medication. Mr. [redacted]admits that he occasionally uses "old Morphine" from a friend. He also uses both insurance and cash to pay for prescriptions. None of Mr. D[redacted]s potentially criminal behaviors are addressed by Dr. Sternstein. In fact, he writes letters, "To Whom it may Concern," that attempt to explain Mr. D[redacted]s possible criminal behavior. Mr. D[redacted] may have been involved in criminal activity and/or misuse and/or diversion of the Controlled Substance prescriptions written by Dr. Sternstein. There are two police reports initiated by Mr. D[redacted]'s wife dated 1/13/09 and 3/23/09 reporting that both jewelry and prescriptions/medication bottles with "pain killers" were stolen. Dr. Sternstein's clinic notes from this time period indicate that immediately after the first "burglary" Mr. D[redacted] attended group therapy and the only notable fact was that he appeared tired. A month after his wife completed the police report, Mr. D[redacted]reported to the clinician that he had increased pain and stress due to conflict with his wife over a recent break in at his house in which his pain medication was stolen. He admitted to use of marijuana due to the stress. The clinician indicated that the patient would discuss this with Dr. Sternstein. There is no indication that he discussed this with Dr. Sternstein, according to the clinic notes. It does not appear that Mr. D[redacted] saw Dr. Sternstein, although he continues to receive multiple prescriptions from Dr. Sternstein. Following the second police report there is no clinic notation made until over two months later, despite the fact that there are multiple prescriptions written for Schedule II controlled substances by Dr. Sternstein for Mr. D[redacted] without documentation that he had been seen by Dr. Sternstein. These practices are well below the community standard of care and put the practitioner at risk for criminal prosecution. It is below the community standard of care to prescribe controlled substances to a patient who is demonstrating misuse or diversion of the medications. It is well below the standard to prescribe controlled substances without evaluating the patient.

An example of Dr. Sternstein's prescription practices of opioid and other medications are prescriptions he wrote for Mr. D[redacted]in July 2009. Dr. Sternstein

prescribes Methadone, 10mg tablets, #200, Oxycontin 20mg extended release tablets, #120, Oxycodone, 30mg tablets, #200, Oxycontin 80mg extended release tablets, #120, Oxycontin, 40mg extended release tablets, #120, Oxycodone 30mg tablets, #100, and NDC, #120. These prescriptions are for excessively high doses of medication and prescribed in combination. This practice is well below the community standard of care.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. The practice of co-signing another practitioners note and prescribing controlled substances without evaluation of the patient by the prescriber is not the community standard of care. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need. Dr. Sternstein prescribed multiple different controlled substances to a patient with a documented history of drug addiction.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. Dr. Sternstein co-signs the clinical notes of other practitioners and prescribes medication based upon these visits without completing his own documented evaluation on numerous occasions. The community standard of care is to coordinate care within a clinic, for instance, one practitioner conducts psychotherapy or testing and the physician conducts the management of medication. Both practitioners would write their own clinic note demonstrating that both individually evaluated the patient and conducted the care appropriate to their discipline. The different disciplines would then confer to devise a complete plan of care. This does not mean the non-physician evaluates the patient and the physician then writes a prescription without seeing the patient or writing his own clinic note, which is the practice that Dr Sternstein appears to conduct. This is a moderate deviation from the standard of care, as he does not conduct every clinic visit in this fashion and it is not possible to be sure from the records provided that Dr. Sternstein was not at least physically present during these evaluations, even though he did not write his own clinic note. "In New York State the practice of permitting, aiding, or abetting an unlicensed person to perform activities requiring a license is professional misconduct." Chapter 58, Ethics in Psychiatry, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.
2. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to

justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

3. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Mr. D[redacted] and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn him of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Mr. D[redacted]s increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
4. Dr. Sternstein is aware the patient has a history of drug addiction and prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating the patient is also using

other opiates that are not prescribed by Dr. Sternstein. Dr. Sternstein was aware the patient was on probation. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior. It is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal conduct. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to this patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov

5. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released:

04/01/2010.

(Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.

rec'd 7/19/10

Consultant Review

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: D[redacted] T[redacted]-W[redacted], DOB: [redacted]
Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Dr. Sternstein's records dated 1/31/08 through 9/23/2009. Letters from Dr. Honor dated 7/29/2002 through 8/18/02, and a letter from Dr. Honor dated 10/26/09, a radiology report dated 1/24/06, a letter from Dr. Sternstein to Probation Officer Wexler dated 4/27/09, and prescription histories and photocopies from CVS, Price Chopper, Beacon South, Beacon, Walgreens, and Rite Aid pharmacies. I have reviewed the Drug Control Division duplicate prescriptions dated 10/1/3008 and 10/2/2008. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
D[redacted] T[redacted]-W[redacted], DOB [redacted] received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 1/31/2008 for a chief complaint of taking pain medications to sleep due to back pain. Ms. T[redacted]-W[redacted] stated that "chasing pills is a full time job." The clinician wrote that the patient was now taking "70-120mg of percocet per day at $100-$150 per day that she crushed and snorted." She stated she bought medications from people who obtained their medications from pain clinics in Bristol and Meriden. She admitted to using the Percocet to sleep. She reported using a maximum of 180-200mg of Oxycodone per day. She is found to have Opioid Dependence and chronic pain. The clinic notes reviewed are dated 2/7/08 through 6/3/09 and several are notes completed by another clinician and are co-signed by Dr. Sternstein. The practice of co-signing another practitioners note and prescribing controlled substances without evaluation of the patient by the prescriber is not the community standard of care.

All of the documentation from the health care record that are hand written barely legible and are composed of patient report of symptoms, social/work history, and the patient's explanation of treatment needs and excuses for unsatisfactory urine toxicology reports. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is

below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail.

In July of 2002, Ms. T[redacted]-W[redacted] was evaluated by the Grove Hill Medical Center Physiatry Department. She presented with back pain that had been on going for six months. She did not have an injury to explain the pain and had been taking Vicodin but wanted something stronger. X-rays of the lumbar spine were normal. There was no pain elicited on physical examination. The physician reported there was no explanation for the patient's back pain. The patient's mother asked that he prescribe Valium for Ms. T[redacted]-W[redacted] and the doctor declined. He ordered an MRI scan and physical therapy. At the same time in July of 2002 Ms. T[redacted]-W[redacted] was evaluated by Dr. Druckemiller for back pain. He diagnosed a small pseudomeningocele at T11-T12, that did not require immediate surgery but should be watched. She did have the pseudomeningocele completely removed on 8/15/2002 at Hartford Hospital by Dr. Druckemiller without complication. She was discharged three days later with a normal examination and relief of pain. Her records also contained an evaluation by the Grove Hill Dermatology department in August of 2005. The evaluation stated that the patient's pain management would be done by her primary care physician, Dr. Honor. In September of 2006 Ms. T[redacted]-W[redacted] had an MRI performed that revealed a small left paracentral disc herniation at L4-L5. These medical records do not support the subsequent medication seeking behavior of Ms. T[redacted]W[redacted] when she began attending Dr. Sternstein's clinic or the large amounts of pain medication that are prescribed be Dr. Sternstein. This does not meet the community standard of care.

Pharmacy and medical records indicate that Ms. T[redacted]W[redacted] received multiple prescriptions for Oxycontin, Oxycodone, NDC, and Suboxone, without any clear past or present indication that she needed multiple prescriptions of opioid medications along with Suboxone. Patients who continue to take opioids should be warned strongly of the dangers of doing so with Suboxone. Dr. Sternstein's medication records beginning 1/31/08 indicate that Ms. T[redacted]-W[redacted] was started on 24/6 mg per day of Suboxone. In addition to the Suboxone, Dr. Sternstein also prescribed Tenex 1mg, twice per day, and Xanax 0.5mg twice per day all on 1/31/2008. By June of 2009, Dr. Sternstein, according to his log, was prescribing for Ms. T[redacted]-W[redacted] Opana ER (Oxymorphone) 40mg, 2 tablets per day, #60 tablets for the month; Oxycontin 60mg, 1 tablet per day, #30 tablets for the month; Oxycontin 40mg, 1-2 tablets per day, #60 tablets for the month; Oxycontin 80mg, 1tablet per day, #30 for the month, Percocet 10mg/325mg, 2 tablets four times per day, #240 tablets for the month (This would be equal to 300 mg of Oxycodone per day. The equivalent dose of morphine would be 150mg per day), and in July of 2009 SOMA (Carisoprodol) was added as well. These prescriptions are for exceedingly high doses of medication and prescribed in combination. This practice is below the community standard of care.

Throughout 2008 and 2009, Ms. T[redacted]-W[redacted] had urine toxicology screens that were positive for street drugs of abuse like cocaine and methadone and negative for the prescribed Suboxone. She filled identical prescriptions at two different pharmacies and used multiple pharmacies in different towns. She

admitted to consuming cough syrup. Pharmacy records indicate she presented prescriptions to the pharmacy that were not filled. All of these behaviors are a red flag for possible misuse and abuse of the prescribed medications by the patient. Dr. Sternstein does not address these in a timely or effective manner. He only continues to prescribe a variety of medications that are well known to cause serious substance dependence at extremely high doses without clear clinical indications for their use. These practices are well below the community standard of care and put the practitioner at risk for criminal prosecution.

There are no objective or even structured subjective evaluations of physical limitation or assessments of the response of the patient's pain to treatment. These prescriptions reflect a substandard level of care due to the prescription of Suboxone in combination with opioid medications, as well as the prescription of Schedule II narcotics without clear indication and in response to patient request rather than clinical rationale.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. The practice of co-signing another practitioner's notes and prescribing controlled substances without evaluation of the patient by the prescriber is not the community standard of care. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. Dr. Sternstein prescribed multiple different controlled substances to a patient with a documented history of drug addiction and criminal misuse of Schedule II controlled substances.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. Dr. Sternstein co-signs the clinical notes of other practitioners and prescribes medication based upon these visits without completing his own documented evaluation on numerous occasions. The community standard of care is to coordinate care within a clinic, for instance, one practitioner conducts psychotherapy or testing and the physician conducts the management of medication. Both practitioners would write their own clinic note demonstrating that both individually evaluated the patient and conducted the care appropriate to their discipline. The different disciplines would then confer to devise a complete plan of care. This does not mean the non-physician evaluates the patient and the physician then writes a prescription without seeing the patient or writing his own clinic note, which is the practice that Dr Sternstein appears to conduct. This is a moderate deviation from the standard of care, as he does not conduct every clinic visit in this fashion and it is not possible to be sure from the records provided that Dr. Sternstein was not at least physically present during these evaluations, even though he did not write his own clinic note. "In New York State the practice of permitting, aiding, or abetting an unlicensed person to perform activities requiring a license is professional misconduct." Chapter 58, Ethics in

Psychiatry, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

2. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.
3. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of the patient's report of pain to treatment. There are no alternative pain interventions offered to Ms. T[redacted]-W[redacted] and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for her pain and to warn her of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of

medication prescribed and the severity of the Ms. T[redacted]-W[redacted] increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.

4. Dr. Sternstein is aware the patient has a history of serious drug addiction and yet he prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating the patient is also using other drugs that are not prescribed by Dr. Sternstein. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior. It is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal conduct. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to this patient. "State laws governing the prescription of opiods to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov
5. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and Suboxone without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive

Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.

6. Dr. Sternstein prescribes Suboxone (a mixed agonist-antagonist opiate) to this patient who is dependent on opiate agonists. It is not standard of care to prescribe opiates with Suboxone as drug interactions are a risk as well as the lowering of effectiveness of both drugs. In addition, serious withdrawal symptoms can emerge as well as increased risk of opiate abuse. Chapter 2, Pharmacology, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.

Consultant Review

Consult Completed by: Suzanne Ducate, M.D. rec'd 7/19/10

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: L[redacted] W[redacted]
Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Ms. W[redacted] dated 7/17/02 through 2/19/2009, Insurance records, reports from Middlesex Hospital, MRI Report dated 7/12/07, MRI report from Dr Jeffrey Bash, dated 10/17/07, Psychiatric Records from Middlesex Hospital Homecare dated 4/9/2008, Middlesex Hospital Homecare records dated 7/17/07, Laboratory reports from Middlesex Hospital dated 4/30/2009, and Open MRI of CT, dated 6/26/2008, prescription history and photocopies from Hancock, Walgreens, and Rite Aid pharmacies. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
L[redacted] W[redacted], [redacted], received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 7/17/2002 for a chief complaint of severe pain. She reported using a cane and wheelchair. The clinician noted that her complaints of pain were dramatic in their presentation. Ms. W[redacted] reported that she had chronic pain since 1984 due to spondylosis, ruptured discs, and bursitis with a C5-C6 fusion. She reported taking multiple pain medications and a history of depression and schizoaffective disorder. She reported multiple other medical conditions as well, including diabetes, hypertension, and gastric esophageal reflux disease. The evaluator made diagnoses of Schizoaffective Disorder, Pain Disorder, probable Borderline Personality Disorder, Spondylopia, Degenerative Disc, Right Carpal Tunnel, Obesity, and Multiple Medical Problems. The clinician's formulation was a history of Schizoaffective Disorder, Chronic Cervical and back pain presenting for pain management. The patient was considered stable on psychotropic medications and she would continue with psychiatrist, Dr. Lieders. The clinician reported that the patient's last Oxycontin dose was taken the night before and she was "now withdrawing."

The medical notations reviewed are dated from 1/8/07 through 5/18/09, some of the notes are typed and others are hand written. Dr. Sternstein's prescription log begins on 1/4/2007. The typed and hand written notations have little objective assessments and do not support the prescriptions written. The patient's report of symptoms, medical and social complaints, and minimal explanations of medical complications are brief and the plans for care are

unsupported by objective evidence of disability or response to treatment. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. There are no objective assessments that evaluate the response of the patient to the treatment. There are no non-pharmacological interventions recommended and there is no evidence that Ms. W[redacted] was provided the information needed to give informed consent for treatment. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail.

Dr. Sternstein prescribed pain medication for Ms. W[redacted] without communicating with her dentist secondary to her complaints of pain due to dental problems. The prescription of controlled substances by a physician for pain due to a dental problems, without communicating with the dentist, who may be prescribing medication for pain as well, is not the community standard of care.

This patient has some objective evidence of pathology that could result in chronic pain, including MRI reports of C3-C5 severe central spinal canal stenosis, moderate degree at C6-C7 and condromalacia of the femoral articular cartilage with a cyst at the right pelvis. She has a history of C5-C6 fusion. There were also responses from insurers allowing high doses of prescribed opiates to be paid for by Medicare. Part of the rationale used by Medicare to approve the doses of opiates was Dr. Sternstein's written statement that "The American Academy of Pain Medicine, American Pain Society, and the Federation of State Medical Boards of the United States have developed consensus guidelines for the use of opioids in opioid tolerant chronic pain individuals. Specifically it is recognized that there is not a dose ceiling for analgesia with this class of medicines and that the safety and effectiveness of the regimen is determined by the level of function and quality of life of the patient balanced against the presence of side effects or evidence for aberrant use. Drug dose and dosing schedule are less relevant." I was unable to locate this quote on a search of the quoted references. This rationale also does not allow the physician to prescribe dangerously high doses of opioid medication without clear rationale based upon extensive ongoing evaluation and monitoring that is not reflected in Dr. Sternstein's medical records. In addition, Ms. W[redacted] engaged in a behavior that would lead a prudent practitioner to suspect misuse or abuse of the medications. In April and May of 2009, Ms. W[redacted] paid $26,974.34 in cash for her prescriptions, when previously insurance was used to pay for prescriptions. She presented over 50 prescriptions to the pharmacy that were not filled and she had multiple prescribers of multiple different medications

An example of Dr. Sternstein's inappropriate prescribing of opioid and other medications is reflected by both Dr. Sternstein's prescription log and the Pharmacy records during August of 2008. Dr. Sternstein prescribed Oxycontin, 80mg, #720 on 8/4/08, Oxycontin, 30mg, #90, again on 8/4/08, NDC, #150 filled on 8/8/2008, Oxycontin 40mg, #660 written on 8/4/2008, a prescription filled on 8/12/2008 for

Oxycodone HCL 30mg, #150, Oxycontin 60mg, #150 on 8/4/08, a prescription filled on 8/21/08 for NDC, #90, Roxycodone, 30mg, #150 on 8/4/08, a prescription filled on 8/26/08 for Oxycontin 40mg, #660, a prescription filled on 8/27/08 for Oxycontin 80mg, #720. These records indicate excessively high doses of opioid medication prescribed to Ms. W[redacted] by Dr. Sternstein.

Another example of Dr. Sternstein's inappropriate prescribing of opioid and other medications, according to his prescription log, that are indicative of the pattern of prescribing he engages in throughout the record, are the prescriptions he wrote for Ms. W[redacted] during the month of January 2009. Dr. Sternstein prescribed Oxycontin 80mg tablets, #1440 for the month, Oxycontin, 30 mg tablets, #180 for the month, Oxycontin 40mg tablets, #1320 for the month, Oxycontin 60mg tablets, #300 for the month, Roxycodone 30mg tablets, #300 for the month, and Fentora 400mcg, #56 for the month . If these medications were taken as prescribed the patient would be receiving 48 pills of 80mg Oxycontin per day, 6 pills of 30mg Oxycontin per day, 44 pills of 40mg Oxycontin per day, 10 pills of 60mg Oxycontin per day. This number of pills at these strengths would be a total of 6380mg of just Oxycontin per day, an equivalent of 3200mg of Morphine per day. This morphine equivalent is 17.7 times the recommended maximum daily dose of morphine or its equivalent. Even if Ms. W[redacted] took the medication every two hours around the clock she would be taking 530mg of Oxycontin at a time. In addition to the Oxycontin, Dr. Sternstein also prescribed Roxycodone and Fentora. These prescriptions are excessively high doses of medication and prescribed in combination. There are no clear indications in the record for the large amounts of medication prescribed. The practice of prescribing massive doses of Schedule II controlled substances, is well below the community standard of care, despite Dr. Sternstein's reference to a consensus guideline.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without clear objective evidence that there is an effective response to the treatment and without monitoring the patient for tolerance and dependence on the medication. Dr. Sternstein prescribes medication for dental pain despite the fact that the dentist is also prescribing pain medication.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. The clinic notes are barely legible, and even when typed, are extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other

sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

2. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Ms. W[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for her pain and to warn her of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Ms. W[redacted]s increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
3. Pain medication is prescribed according to Dr. Sternstein's records to treat pain secondary to dental problems. There is no evidence that this treatment was coordinated with the dentist or that the dentist requested consultation from Dr. Sternstein for pain management. The community standard is to coordinate care with the dentist if both the physician and the dentist may be

prescribing medication for pain. This is a severe deviation of the standard of care due to the high risk of toxicity.

4. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and other addictive medications without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5
U.S. Food and Drug Administration, www.FDA.gov, 2010.

5. Dr. Sternstein refers to The American Academy of Pain Medicine, American Pain Society, and the Federation of State Medical Boards of the United States consensus guidelines to justify the excessively high doses of opioid medications he prescribed to Ms. W[redacted]. (See attached documents.) A review of these documents does not reveal the simplistic justification Dr. Sternstein gives to explain the doses of medication he prescribed Ms. W[redacted]. The Federation of State Medical Boards of the United States, Inc., Model Policy for the use of Controlled Substances for the

Treatment of Pain, dated May 2004, states "Many terminally ill patients unnecessarily experience moderate to severe pain in the last weeks of life." This is not Ms. W[redacted]'s situation. The document also states, "The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain, and treatment outcomes." These recommended interventions are never done by Dr. Sternstein. He does not use any objective or even semi-objective ongoing assessments of the response of the patient to the treatment. He does not offer non-pharmacologic interventions other than a very loosely defined "pain group" that is not run by Dr. Sternstein. The document continues with, "All such prescribing must be based upon clear documentation of unrelieved pain," which is not the practice of Dr. Sternstein. Further, the State Medical Boards report guidelines state, "a medical history and physical examination must be obtained...it should document the nature and intensity of the pain." This is never documented in Dr. Sternstein's medical records. The State Medical Boards further recommend, "informed consent and agreement for treatment," which is not present in Dr. Sternstein's records. There are also recommendations for periodic reviews, consultations, and compliance with controlled substances laws and regulations, which Dr. Sternstein does not document. The American Pain Foundation, Consensus Statement in Support of H.R. 1020, the National Pain Care Policy Act of 2005 (see attached), reports advocacy for adequate pain treatment but there is not a statement as quoted by Dr. Sternstein, "Specifically it is recognized that there is not a dose ceiling for analgesia with this class of medicines and that the safety and effectiveness of the regimen is determined by the level of function and quality of life of the patient balanced against the presence of side effects or evidence for aberrant use. Drug dose and dosing schedule are less relevant." I have done an extensive search and cannot find this statement made by the American Pain Foundation or The Federation of State Medical Boards of the United States.

Consultant Review

Consult Completed by: Suzanne Ducate, M.D. rec'd 7/19/10

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: K[redacted] O[redacted] K.O'C.

Date Review Completed: July 17, 2010

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Ms. O[redacted] dated 6/27/00 through 6/18/2009, Insurance records, an evaluation by Grove Hill Medical Center Physiatry dated 5/19/00, an MRI report dated 9/9/02, and a letter from CT Neurosurgery and Spine Associates dated 11/4/04, and prescription history and photocopies from Walgreens, Wal-Mart, and XPECT pharmacies. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
K[redacted] O[redacted], DOB[redacted], received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 6/27/2000 for a chief complaint of pain. She stated she was currently in treatment for depression and anxiety with Dr. Carre, a psychiatrist, who was prescribing Zoloft, Ativan, and Trazadone. The substance abuse history was left blank. She reported that her pain was due to herniated discs secondary to heavy lifting. She reportedly was referred for pain treatment by her orthopedic specialist. Although she denied substance abuse, she was a member of Alcoholics Anonymous.

Ms. O[redacted] was evaluated by Physiatry at Grove Hill Medical Center on 5/19/00. The history noted a patient with multiple occupational claims of disability, injuries due to falls, and drug seeking behavior for Vicodin. She was on Medicare Disability at the time of the evaluation. On examination the patient was obese and the exam revealed no objective physical deficits. Dr. Pepperman recommended pain management and noted that there was narcotic analgesic abuse evident. He recommended the Grove Hill psychiatry team to wean Ms. O[redacted] from narcotics. On 9/9/02, Ms. O[redacted] underwent an MRI scan of the spine and a moderately large central herniated disc was found at C4-C5. CT Neurosurgery and Spine Associates evaluated Ms. O[redacted] on 11/4/2004 and found she complained of pain and reported she was taking Oxycontin, Klonopin, Xanax, and Zoloft. Dr. Wakefield reported that he could not elicit any clear radicular findings on examination and did not find evidence of myelopathy either. He did not recommend surgical intervention.

Dr. Sternstein's clinic notes are completed by other clinicians and co-signed by him one third of the time. He also provides Ms. O[redacted] with prescriptions

without an office visit at all on multiple occasions. Despite Ms. O[redacted] evaluations by Orthopedic and Physiatry specialists, who do not find objective evidence to support the patient's report of debilitating pain, Dr. Sternstein, according to his prescription log, in January 2007 prescribes in one day, January 15, 2007, Oxycontin 80mg, 17 tablets per day, #240 total tablets, Xanax 1mg, 4 tablets per day and #60 tablets, with 2 refills, and 40mg Oxycontin, 8 tablets per day and #120 tablets. Prescription of narcotic medications at extremely high doses and with such large numbers of tablets in one visit without any objective evidence of need is well below the community standard of care.

Clinic notes reviewed dated 10/30/2007 through 6/11/09 are barely legible, composed of patient report of symptoms, social/work history, and the patient's explanation of treatment by other providers. When Dr. Sternstein prescribes Abilify (a non-narcotic antipsychotic medication) the patient chooses not to take it and Dr. Sternstein does not address this as a problem, he only continues to prescribe the medications the patient prefers, which are narcotics and benzodiazepines. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by the clinician regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self-report and patient preference only, and the documents lack sufficient detail.

In addition, the Drug Control Division Report indicates that the Connecticut Department of Social Services identified Ms. O[redacted] as at high risk for drug abuse and required her to participate in a Drug locked-in program to avoid insurance abuse. As of March 31, 2008 Ms. O[redacted] was to use Walgreens in Berlin, CT to fill all of her prescriptions. However, during the week of 4/26/2009 it was discovered that Ms. O[redacted] had been filling Xanax prescription at Wal-Mart every 15 days and paying with cash for over one year, to avoid detection by the locked-in program. She was also filling prescriptions for Xanax at Walgreens, her identified pharmacy, under her Medicaid insurance every 15 days. In addition, there were also 41 prescriptions written for Ms. O[redacted] that she did not fill. There were prescriptions filled that were not documented in the medical records. From January 23, 2009 through May 14, 2009, Ms. O[redacted] paid cash for Oxycontin prescriptions. In May, 2009, she spent about $3300 in cash for prescriptions of Xanax and Oxycontin. Urine toxicology screens are inconsistent with Dr. Sternstein's prescription log and he fails to address this with the patient. This is below the community standard of care.

Dr. Sternstein wrote several letters to Humana Insurance Company advocating for the approval of extremely high doses of Schedule II medications, despite evidence of medication misuse. He states in his letters that the patient is on extraordinarily high daily doses of oxycodone but claims these excessive doses allow her to improve her quality of life without evidence of substance abuse. Dr. Sternstein fails to mention Ms. O[redacted] has been limited to one pharmacy but did

not adhere to the DSS limitation and had been filling prescriptions at an alternate pharmacy and paying with cash. This practice by Dr. Sternstein is well below the community standard of care.

All of the records reviewed indicate both possible misuse and diversion of prescriptions for criminal purposes. A responsible practitioner would at least consider that the patient was misusing or abusing the prescribed medication. The practice of prescribing massive doses of Schedule II controlled substances, as well as other sedating and activating medication is well below the community standard of care, especially when there is evidence of misuse.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary. Dr. Sternstein prescribes extremely high doses of multiple different controlled substances to a patient with a documented history of drug addiction. Dr. Sternstein ignores objective evidence of patient misuse of narcotic medication, and in fact writes letters to her insurance company reporting the opposite, which is a clear obfuscation of the facts by Dr. Sternstein. This is not only below the community standard of care but also enters the realm of criminal and unethical practice.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients well known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use

of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

2. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Ms. O[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for her pain and to warn her of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Ms. O[redacted]'s' increasing dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.
3. Dr. Sternstein is aware the patient has a history of drug and alcohol addiction and prescribes high doses of opiates, which are well known to be addictive and despite evidence from urine drug screens indicating that Ms. O[redacted] is also using narcotics not prescribed by Dr. Sternstein. Dr. Sternstein was aware the patient has a significant history of drug abuse and dependence. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction and criminal behavior. It is the standard of care to ensure the patient is not misusing the medication or engaging in further criminal conduct. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient with objective evidence of engaging in criminal and dangerous behavior is a serious disservice to the patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the

treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov

4. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and other addictive medications without addressing tolerance and potential lethal toxicity with the patient. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.

Consultant Review

Consult Completed by: Suzanne Ducate, M.D. 7/19/10

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: P[redacted] B[redacted]
Date Review Completed: July 17, 2010
Date of Death: 11/29/08

Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Mrs. B[redacted] dated 10/8/01 through 11/5/08, Insurance correspondence, Records from New Britain General Hospital, University of CT Health Center records, Primary Care Provider records, Surgeon's office records, Orthopedic Consultant records, Police Reports, Report from the office of the Medical Examiner, including autopsy report, a statement made by the decedents daughter, and Walgreens prescription history and photocopies of prescriptions. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
P[redacted] B[redacted], DOB[redacted] received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 10/08/01 for a chief complaint of "I had to make a choice because of insurance." She reported that she had been treated on and off for 12 years and was stable on her present medications. She denied substance abuse history and endorsed symptoms of depression and anxiety. She stated she was on disability and taking medication for pain and psychotropic medication for depression and anxiety. She was diagnosed with chronic pain and psychiatric issues, with a recommendation for medication management, as the patient was not interested in pain group or psychotherapy. The chart notes reviewed are dated 11/2/06 through 11/5/08. There are nonspecific plans noted for treatment and follow up. There are letters from Mrs. B[redacted] requesting additional medication prescriptions. There are no notes of physical examinations and very few objective observations by Dr. Sternstein regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimens. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. It is not the community standard of care to prescribe large doses of opiate medication to treat pain based solely upon the patient's report of pain, letters from the patient requesting more medication, the

patient's report of interventions by other doctors, and psychosocial complaints rather than objective assessments of a response to treatment.

As early as March of 2003, medical records from New Britain General Hospital indicate that Mrs. B[redacted] was abusing prescription medication due to her presentation in the emergency room with bizarre behavior, including a report of visual hallucinations and an objective assessment of disorientation and incoherent speech. She was discharged from the hospital with a diagnosis of organic mental syndrome due to opiate withdrawal. She had abruptly stopped her medications due to insurance payment issues. Dr. Sternstein wrote a letter dated 9/1/06 that Mrs. B[redacted] had been his patient since 2001 and she was unable to work due to multiple medical conditions, as well as multiple medications that rendered her permanently disabled. She was again hospitalized in February of 2007 at New Britain General Hospital, for lethargy and a change in mental status due to opioid use. The discharging physician called Dr. Sternstein to discuss the patient's discharge medications. The physician wrote that she suspected the patient's elevated liver function tests were due to high amounts of opiate medications, antipsychotic medications, and a fatty liver. In May of 2007 Mrs. B[redacted] was seen at the University of Connecticut Health Center due to rectal bleeding and multiple medical problems. She was seen at UCONN again in June of 2007 for an ankle injury. The x-rays revealed degenerative changes but no acute injury, other than soft tissue swelling. The records from her hospital visits reflect a primary problem of opiate toxicity. The hospital visits do not reflect problems with chronic pain or significant acute injury. The patient is seen due to problems associated with excessive opiate medication. In July 2008 Mrs. B[redacted] was admitted to The Hospital of Central Connecticut for treatment of pneumonia. On his discharge summary the hospitalist noted that the patient was not a reliable historian and would change her history. "Initially she stated she was not on Methadone. Then while in the hospital she requested high doses of Methadone, saying that Dr. 'Steriene', who is following her for chronic back pain, used to write her Methadone at 160mg three times per day. It was decide that a the patient was not a reliable historian, and the dose was confirmed with her physician, but as she stated that she was not consistent with taking this medication, the patient was started on a lower dose." Mrs. B[redacted]'s problems as documented by more than one hospital are primarily due to excessive use of opiate medication, as well as inconsistency in reporting how much opiate medication she was taking that was prescribed by Dr. Sternstein. It is not the community standard of care to continue to prescribe high doses of opiate medication in addition to other medications that result in sedation and respiratory depression, after a patient has had hospital admissions indicating both opiate toxicity and addiction.

Dr. Sternstein's prescription log indicates a pattern of inappropriate prescribing of opioid and other medications. He prescribes very high doses and many medications at the same time, including valium, methadone, SOMA, Ambien, Fentora, Lamictal, Cymbalta, and others. In addition, pharmacy records indicate prescriptions filled that are not recorded in the medical records of Dr. Sternstein or prescriptions written that are not filled. Just prior to Mrs. B[redacted]'s death, during the months of October and November of 2008, Dr. Sternstein, according to his own

log, prescribed Dilaudid 8mg, #240, Methadone 10mg, #1320, Norco, 10/325mg, #180, Xanax 2mg, #60, and Flexeril 10mg, #60. The practice of prescribing massive doses of Schedule II controlled substances, as well as other sedating medication is well below the community standard of care, especially with Mrs. B[redacted]'s history of hospitalizations due to opioid toxicity and her history of unreliable reporting of her medication use.

Ultimately, Mrs. B[redacted] died and the medical examiner reported on 1/22/2009 that the cause of death was opiate toxicity. The Berlin Police Report dated 10/6/2009 described the manner in which Mrs. B[redacted] was discovered deceased at the age of 52. The police arrived at the decedents address on 11/29/08 and were met by her husband, S[redacted] B[redacted]. He reported that he last observed his wife alive the night prior on 11/28/08 watching television. He claimed that he discovered her on the floor at 6 am on 11/29/08 and spent 30 minutes trying to awaken her before he called emergency services. When emergency personnel arrived, she was already rigid and no resuscitation efforts were made. Her husband reported that she commonly fell from bed and he did not think the situation was severe. She was found in a large pile of vomit and her husband told the police that Mrs. B[redacted] commonly vomited due to her addiction to pain medication. He stated they were both addicted to pain medication. Their daughter, J[redacted] B[redacted] in her statement reported that she was always heavily medicated and she wondered how one person could be on so much medication. There were multiple bottles of medication on the scene. The police report indicated that both P[redacted] and S[redacted] B[redacted] were on very extensive prescription drugs, mainly narcotic pain killers and antidepressant drugs under the care of Dr. Gerson Sternstein. Mr. B[redacted] admitted that he and his wife shared prescription pain medications. When Mrs. B[redacted]'s body was removed pill fragments were noted in the vomit. The police report concluded that it appeared that Dr. Gerson Sternstein had prescribed an extensive amount of controlled drugs/narcotics that may have been a contributing factor in the B[redacted] death. The circumstances of Mrs. B[redacted]'s death are extremely unfortunate. She was a middle-aged woman, who despite some chronic medical problems, suffered an untimely and avoidable death due to a severe addiction to opiate medications both caused by and untreated by Dr. Gerson Sternstein. This represents a severe deviation from the community standard of care. Despite multiple indications over a prolonged period of time that Mrs. B[redacted] suffered from a severe addiction to opiate medications, Dr. Sternstein not only did not address the addiction, but also prescribed lethal doses of medication in combination that ultimately led to her death.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary, such as hospitalizations for opiate toxicity and multiple objective indications that the patient was seriously addicted to pain medication. The prescription of extremely high doses of opiate medication, and medications in combination with a high likelihood of toxicity, by Dr. Sternstein resulted in the

untimely death of this patient.

Summary of Findings:
The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphene in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.
2. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Ms. B[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn her of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe

deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Ms. B[redacted]'s evident dependence on opioid medication. Clinical Guidelines for the use of Buprenorphene in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.

3. Dr. Sternstein is aware the patient is misusing medications and is drug addicted, but he prescribes high doses of opiates anyway, which are well known to be addictive. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction. It is the standard of care to ensure the patient is not misusing or abusing the medication. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient is a serious disservice to this patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphene in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin. These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov
4. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and other addictive medications without addressing tolerance and potential lethal toxicity with the patient. This patient unfortunately died of opiate toxicity. The medical examiner's report clearly states the cause of death was opiate toxicity. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive

Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.

rec'd 7/19/10

Consultant Review

Consult Completed by: Suzanne Ducate, M.D.

Respondent: Gerson Sternstein, M.D. **Petition No:** 2009-0115-001-009
2009-200921

Petitioner: S[redacted] B[redacted])
Date of Death: 10/13/2009
Date Review Completed: July 17, 2010
Investigator: RoseMarie Deschenes
Date Received for Review: 4/9/2010

Records Reviewed:
Records of Dr. Sternstein regarding Mr. B[redacted] dated 9/11/2001 through 9/3/2009, Primary Care Provider office records, Hebrew Healthcare records, Rocky Hill Skilled Nursing Facility records, New Britain General Hospital records, Police Reports, Report from the office of the Medical Examiner, including autopsy report, a statement made by Mr. B[redacted]'s daughter, J[redacted] B[redacted] dated 9/21/2009, and Walgreens prescription history and photocopies of prescriptions. I have reviewed the above data listed provided by the investigator and any relevant clinical material.

Complaint Review:
S[redacted] B[redacted], DOB (4/21/1951), received an initial evaluation by a clinician with an illegible signature working for Paragon Behavioral Health and co-signed by Dr. Sternstein on 9/11/01 for depression, sleep, and pain problems. He reported that he had been treated on and off for 15 years and he had lost jobs due to back pain. He reported use of alcohol rarely and only experimented with drugs of abuse in the 1960's and 1970's. He reported a history of ADHD and stated he was taking Valium, Ritalin, Effexor, Trazadone, Depakote, Vicoden, SOMA, Lopressor, Celebrex, Motrin, and Flomax. He was diagnosed with Depression, current, moderate; hypertension; and chronic back pain. Recommendations were for medication evaluation and monitoring by Dr. Sternstein. A discharge summary from John Dempsey Hospital dated 2/3/2003 noted that the patient had a history of IV drug abuse discontinued in 1977, with Hepatitis B, Hepatitis C, chronic narcotic addiction, hypertension, and depression. He had been admitted for bilateral shoulder hemiarthroplastics due to chronic dislocated shoulders. He had been sent to the ICU postoperatively due to a significant increase in narcotic usage requiring monitoring. Follow up revealed good recovery from surgery. Dr. Sternstein's chart notes reviewed are dated 2/20/07 through 10/1/09. The notes are very brief, almost illegible, and have very little content. There are nonspecific plans noted for treatment and follow up. There are no notes of physical examinations and very few objective observations by Dr. Sternstein regarding the patients functioning or mental status. The plans do not include any details of the prescribed medication regimen. It is not possible to determine from reading these entries what the exact prescribed therapy is or how it relates to the patient's self report. Dr. Sternstein mentions the patient's difficulty with falls and frequent hospital admissions but

does not coordinate the patient's care with other treatment providers. Most disturbing is that in August and September of 2009 when Dr. Sternstein's clinic notes demonstrate that he is aware that Mr. B[redacted] was taken off of the schedule II narcotics that were most likely responsible for his multiple falls and altered mental status, he resumes prescription of methadone and other sedating medications anyway. All of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. It is not the community standard of care to prescribe large doses of opiate medication to treat pain based solely upon the patient's report of pain, the patient's report of interventions by other doctors, and psychosocial complaints rather than objective assessments of a response to treatment.

Mr. B[redacted]'s medical records indicate he had multiple falls and episodes of confusion. ProHealth physicians evaluated Mr. B[redacted] on 6/16/08 and documented a large bruise secondary to a fall due to confusion and dizziness. The assessment was medication induced dizziness. Mr. B[redacted] was admitted to New Britain General on 7/16/08 for a fall and confusion. He was noted to have common bile duct dilation due to chronic opioid use and a fall due to polypharmacy with pain medication and muscle relaxants. Other causes for the fall were ruled out. Mr. B[redacted] fell on 1/13/09, Berlin Police were called and he was taken to New Britain General Hospital due to slurred speech, unsteady gait, and suicidal thoughts. He was admitted on 3/4/2009 to New Britain Hospital of Central Connecticut for cellulitis and narcotic overdose, as well as hypertension, opioid addiction and hepatitis. He was admitted after police found him on the floor of his home with an altered mental status. The hospital record noted that it was the 12th time a police officer had been called to the residence. When he was taken off of narcotics his mental status improved. The Valium and Soma were stopped as well. The cellulitis resolved with antibiotics and he was discharged on 3/9/2009. He was admitted to New Britain General on 3/19/09 for depression and abuse of opiates and benzodiazepines. He was discharged on 3/27/09. Mr. B[redacted] was again admitted on 5/6/2009 to New Britain General for mental status changes. He was believed to have fallen but the patient did not remember. He was treated for a urinary tract infection and discharged on 5/8/09. Berlin Police were called on 7/12/09 after Mr. B[redacted] fell and couldn't get up. He was confused and had taken 56 Xanax. He was again taken to New Britain General Hospital. Mr. B[redacted] was again admitted on 7/16/09 to New Britain General Hospital of Central Connecticut for generalized weakness, frequent falls, and unsteady gait. He was discharged to rehabilitation at Rocky Hill Health and Rehabilitation on 7/22/09 where he remained until 7/30/09. He was then admitted on 7/30/09 to Hebrew Health Care on a 15 day Physician Emergency Certificate for delusional thinking, auditory and visual hallucinations and staff assault. These symptoms and behaviors were most likely due to opiate withdrawal. Mr. B[redacted] was then readmitted to Rocky Hill Nursing Home from 8/10/09 through 8/24/09 and all of his medications were tapered and discontinued. He was no longer prescribed methadone, or other narcotics, according to the discharge paperwork. It was after this discharge that Dr. Sternstein's records indicate, as mentioned above, that he resumed prescribing

narcotics to Mr. B after he had been successfully taken off of them in the controlled environment of the nursing home. It is not the community standard of care to resume narcotics and continue to prescribe high doses of opiate medication in addition to other medications that result in sedation and respiratory depression, after a patient has had multiple police interventions, emergency room visits, and hospital admissions for falls, altered mental status, and psychosis due to opiate toxicity and addiction.

Walgreens pharmacy records indicate that after Mr. B ceased filling prescriptions on 7/9/09 when he was admitted to the hospital after taking an overdose of Xanax. Shortly after his release back to his home on 8/24/09, he again resumed "treatment" with Dr. Sternstein and filled the following prescriptions written by Dr. Sternstein between 9/3/09 and his death on 10/13/09: filled on 9/3/09, Methadone 10mg, #30; filled on 9/10/09, Methadone 10mg, #30; filled on 9/11/09, Lamotragine 25 mg, #30; filled on 9/11/09, Abilify 5mg, #30; filled on 9/11/09, Xanax 1mg, #30, filled on 9/11/09, Seroquel 300mg, #30; filled on 9/11/09, Buproprion SR 150 mg, #60; filled on 9/17/09, Methadone 10mg, #30; filled on 9/24/09, Methadone 10mg, #30; filled on 10/1/09, Methadone 10mg, #30; filled on 10/1/09, Seroquel 300mg, #60; filled on 10/1/09, Buproprion XL 300mg, #30; filled on 10/7/09, Lamotrigine 25mg, #30; and filled on 10/8/09, Methadone 10mg, #30. Unfortunately, Dr. Sternstein again placed Mr. B, after a prolonged detoxification and nursing home treatment, back on a complicated medication regimen. Mr. B was prescribed opiate medication, along with antipsychotic medication, antidepressant medication, benzodiazepine medication (the exact medication he had previously overdosed on), antidepressant medication, and anticonvulsant medication. All of these medications in combination present the same propensity for mental confusion, gait instability, and toxicity Mr. B had experienced previously when he was falling regularly and experienced multiple hospital admissions for altered mental status.

Ultimately, Mr. B died and the medical examiner reported on 2/12/09 that the cause of death was hypertrophic dilated cardiomyopathy. The toxicology revealed positive results for his prescribed medication. The Berlin Police Report dated 10/13/09 indicated that they responded to a call for an untimely death made by Mr. B's nephew. Upon arrival, Mr. B was lying face down on the floor naked, was cold, stiff, and unresponsive. EMS declared him dead on the scene. The police officer reported he had been called to B's apartment numerous times for assist ambulance calls. The officer reported he had found Mr. B lying next to his bed unconscious on the floor in the past. The police report stated that Mr. B has always suffered addiction to prescription drugs. The officer found a large amount of prescription drugs on the kitchen table and two of the bottles were empty even though they were recently filled by Walgreens pharmacy. The prescription bottles indicated the contents had been Methadone and Seroquel. A second police report dated 10/14/2009 completed by the detective division indicated that there was a small pool of blood/fluid directly under the victim's mouth and nose area. The detective noted a very large quantity of prescription drugs in the kitchen area. An inventory of the drugs in the kitchen revealed a total of twenty three prescription drug containers with various amounts ranging from

full/partially full/ and empty. The detective noted that the bottle labeled Methadone 10 mg, #60, dated 10/8/09 was completely empty. He estimated pills should have been left in the bottle if taken as prescribed. Upon search of the house, eight additional prescription bottles were found in plain view in the bedroom. Dr. Sternstein prescribed at least 13 of the prescriptions found. Mr. B[redacted]'s daughter, J[redacted] B[redacted], in a written statement dated 9/21/09 reported that her father suffered multiple falls and was always on a lot of medication. She reported that her father's condition worsened after her mother's death on 11/27/2008. She states that her father told her he was sorry he took too many medications. She describes an incident when her father went to see Dr. Sternstein and was intoxicated with prescribed narcotics. She states Dr. Sternstein recognized her father was intoxicated, made him wait in the office for an hour to "cool down" and he still left with his refills. She states that Dr. Sternstein always made sure her father left with medication prescriptions. Ms. B[redacted] believed her father's falls were due to excessive medication prescribed by Dr. Sternstein. She received multiple calls from the Berlin Police Department that her father was activating his medical alert button due to falling and his inability to get up. There were times she walked into his home and he was on the floor. At those times she found her father shaky and unable to communicate clearly. She stated she would have to call 911 for assistance in getting her father off the floor. She reports that he always appeared overmedicated and stated that she became so distraught that she obtained power of attorney and conservatorship in June of 2009. Ms. B[redacted] reports that her father was "doing great, she saw a whole new person" after he went to the Rocky Hill Nursing Home. On August 24th, he was discharged back to his home in Berlin and was not taking any narcotics, which she believed was his problem. She states her father went back to Dr. Sternstein in September of 2009. It is unclear why Dr. Sternstein began prescribing multiple medications again, just prior to the patient's death, with significant toxic effect to Mr. B[redacted] after he had successfully been taken off of the medication with a positive effect.

In summary, all of the documentation reviewed is below the community standard of care because there are no objective assessments noted, the plan of care is completely based upon patient self report only, and the documents lack sufficient detail. Dr. Sternstein casually prescribes high doses of controlled schedule II medications without any objective evidence of their need and with objective evidence to the contrary, such as hospitalizations for opiate toxicity, suicidal thoughts, unstable gait leading to falls, and altered mental status. There were multiple objective indications that the patient was seriously addicted to pain medication. The prescription of extremely high doses of opiate medication, and medications in combination with a high likelihood of toxicity, by Dr. Sternstein resulted in multiple adverse outcomes for this patient.

Summary of Findings:

The documents reviewed indicate practice issues of Dr. Sternstein that clearly do not meet the community standard of care:

1. The clinic notes are barely legible, extremely brief, and do not indicate a physical exam and rarely a mental status exam or an observation of the

patient's condition and behavior. The plans do not reflect the symptoms reported and are unclear due to brevity. The care appears to be driven primarily by patient request and report, without objective indicators to justify the medication prescribed. Standard practice in the community is clear, legible documentation of the patient's stated complaints and symptoms, historical information, including information from other sources, such as prior treatment records, an objective assessment of the complaint such as physical examination, mental status examination, testing, or other objective measure of the problems presented. Then a clear assessment of the diagnosis is made with a detailed plan of care and follow up. This is a moderate deviation in standard of care as other physicians in the community who care for a large volume of patients known to them document less detail in their outpatient records than is ideal. However, as in Dr. Sternstein's case, when the treatment is outside the usual community practice, good documentation is even more important to justify the deviation from the standard. Chapter 7, The Clinical Examination of the Psychiatric Patient, Kaplan and Saddock's Synopsis of Psychiatry, Ninth Edition. Lippincott, Williams, and Wilkins Publisher, 2003. Chapter 3, Patient Assessment, Chapter 4, Treatment Protocols, and appendix, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. Chapters 1-3, Bates Guide to Physical Examination and History Taking, Ninth Edition, Lipincott, Williams, and Wilkins, 2007.

2. There is no evidence that response to treatment is assessed through standard measures used to monitor the response of chronic pain to treatment. There are no alternative pain interventions offered to Mr. B[redacted], and the risks, benefits, and alternatives to treatment with opiates is not explained to the patient. The standard of care when treating pain is to continually monitor the patient's response to treatment with objective or structured subjective measures and strive to maintain the patient on the lowest dose possible of the opiate medication. It is the standard of care to inform the patient of other possible treatments for his pain and to warn him of side effects and risks to opiate treatment, including the risk of serious drug dependence with the potential for tolerance and withdrawal. It is also necessary to inform the patient of the risk of lethal overdose with these medications as they can result in lethal overdose, particularly with the amounts of medication prescribed by Dr. Sternstein. This is a severe deviation from the standard of care due to the lethal doses of medication prescribed and the severity of the Mr. B[redacted]'s evident dependence on opioid medication. Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004.

3. Dr. Sternstein is aware the patient is drug addicted and suffers many adverse events due to this addiction, but he prescribes high doses of opiates anyway, which are well known to be addictive. The standard of care is to carefully prescribe schedule II controlled substances to any patient, especially one with a history of addiction. It is the standard of care to ensure the patient is not misusing or abusing the medication. This is a severe deviation from the standard of care as the practice of prescribing increasing doses of scheduled II medication to a clearly dependent patient is a serious disservice to this patient. "State laws governing the prescription of opioids to known substance abusers may place prescribing physicians at risk for prosecution unless the medical record clearly distinguishes between the treatment of the addiction and treatment of the pain condition." "The Drug Enforcement Administration frowns on the use of .....spurious and ill defined pain conditions to justify unsanctioned opioid maintenance. "Chapter 5, Special Populations, Clinical Guidelines for the use of Buprenorphine in the treatment of Opiate Addiction, A Treatment Improvement Protocol 40, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Laura McNicholas, M.D., PhD., Consensus Panel Chair, 2004. "Oxycodone is often used to prevent the onset of opiate withdrawal by street users of methadone and heroin These products are highly attractive to opioid abusers and doctor shoppers." U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, Drugs and Chemicals of Concern, Oxycodone, October 2009, usdoj.gov
4. Dr. Sternstein prescribes excessively high doses of opioid medication. He continues to use combinations of opioids and other addictive and sedative medications without addressing tolerance and potential lethal toxicity with the patient. This patient unfortunately died after a long documented history of adverse outcomes due to narcotics addiction. The community standard is to prescribe much lower doses of medication and for a defined length of time. It is substandard care to prescribe schedule II controlled medications for unclear indications. This is a serious deviation from the community standard of care as it clearly puts the patient at extremely high risk of dependence and lethal overdose. "Most patients who require opioid therapy present with acute monophasic pain that may accompany trauma or a procedure and is expected to be self-limited. The short term administration of an opioid drug is considered appropriate." "The role of opioid therapy in non-cancer or non-progressive chronic pain syndromes is less well accepted, such as arthritis or nerve injuries and back and neck pain." Chapter 17, Pain and Addiction, Clinical Textbook of Addictive Disorders, Richard J. Frances, etal, The Guilford Press, 2005. "The usual starting dose of Oxycodone is 5-15 mg every four to six hours."Drugs.com, 2010, Drug Information on Line. "In view of the important dose-related adverse effects, such as opioid-induced hyperalgesia, it would seem prudent to limit the dose of opioids in patients with chronic musculoskeletal pain. Daily doses above 180 mg of morphine or its equivalent have not been validated in clinical trials." Medscape, Nature Review Rheumatology,"Adverse Effects of Chronic Opioid Therapy for

Chronic Musculoskeletal Pain," Leslie J. Crofford, MD, CME Released: 04/01/2010.

Multiplication Factors for Converting the Daily Dose of Current Opioids to the Daily Dose of Oral Oxycodone[1]* (mg/Day Opioid x Factor = mg/Day Oral Oxycodone)

Oral Opioid :

Oxycodone 1
Codeine 0.15
Hydrocodone 0.9
Hydromorphone 4
Levorphanol 7.5
Meperidine 0.1
Methadone 1.5
Morphine 0.5

U.S. Food and Drug Administration, www.FDA.gov, 2010.